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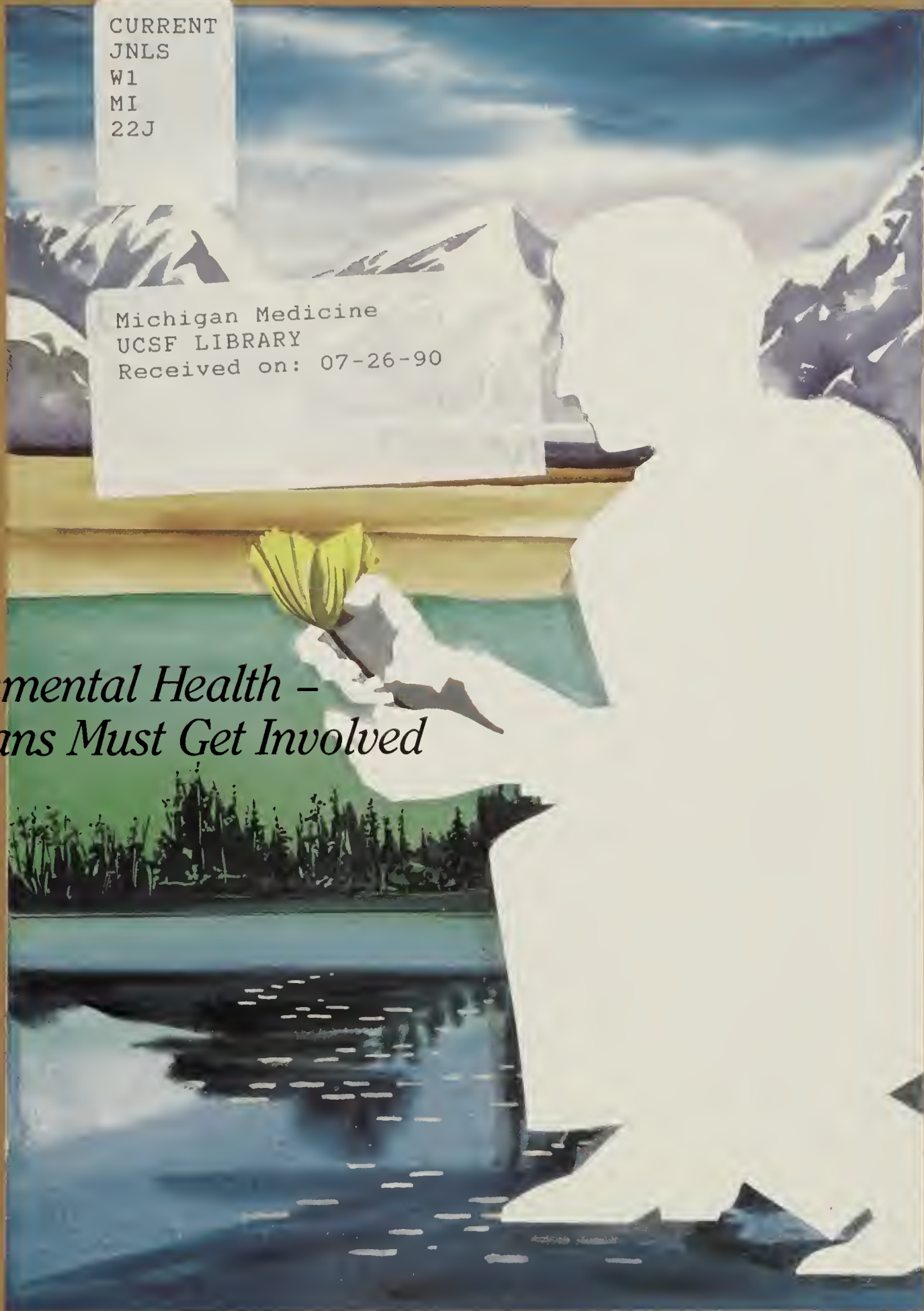
*Award-Winning
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14 COVER STORY

Physicians' concern about the environment, and human health effects of environmental hazards, was strongly evident at the 1990 MSMS House of Delegates. MSMS members acted on several resolutions urging Michigan physicians to become a leader in responding to major environmental concerns. Because of these actions taken by the House, environmental health is the subject of this month's cover story. Included in the cover story is a report from the Michigan Council on Environmental Quality; an explanation of Michigan's Medical Waste Regulatory Act of 1990; an examination of the impact of low level radioactive waste on medical care; a review of a proposal by the Genesee County Medical Society regarding low level radioactive waste; and finally, a message from MSMS President Susan H. Adelman, MD.



Page 14

FEATURES

27 NEW BLUES PAR AGREEMENT

Professional input was key to developing this new contract.

BY JAMES L. GERARDI

31 MSMS LAUNCHES RESIDENT/MENTOR CAMPAIGN

The objective of this new membership recruitment effort is to ensure that resident physicians continue to help shape the goals of organized medicine.

35 GENESEE COUNTY AUXILIARY LAUNCHES SEX EDUCATION CENTER

Genesee County has a new human sexuality education center, thanks to the Genesee County Medical Society Auxiliary.

BY JUDY MCLEOD

37 DEAN SIENKO, MD, PHYSICIAN VOLUNTEER

This fifth in a series of articles on physician volunteers explores the efforts of a Lansing doctor to help educate and inspire students about pursuing a medical career.



Page 35

DEPARTMENTS

- | | | | |
|----|--|----|--|
| 5 | In My Opinion
<i>"Medical Waste Regulatory Act merely formalizes existing system"</i>
BY KENNETH ROWE, MD | 42 | New Members |
| 7 | Letters | 44 | Meetings |
| 9 | Newsfronts | 45 | Category I Courses |
| 10 | Physicians in the News | 47 | Classifieds |
| 41 | Deaths | 49 | Advertising Index |
| | | 50 | President's Page
<i>"MSMS must allocate time, money to public health, environmental issues"</i>
BY SUSAN H. ADELMAN, MD |

In next month's issue of *Michigan Medicine*:
MSMS House of Delegates proceedings.

Cover illustration by: Robert L. Brent.



Page 37

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IN MY OPINION

Medical Waste Regulatory Act merely formalizes existing system

By Kenneth E. Rowe, MD



The phrase medical waste immediately conjures up images of syringes, scalpels and other discarded medical items washing up on lake and ocean beaches.

The public outcry following the waste washups in 1988 led to new federal regulations on tracking medical waste which were at best, cumbersome. When Michigan opted to develop its own system, instituting emergency rules in 1989, MSMS played a role in ensuring that the rules, while providing accountability, were more reasonable than were federal regulations. MSMS provided feedback to the Michigan Department of Public Health on development of the rules and cooperated in getting out information about them.

The Medical Waste Regulatory Act, enacted on March 1 this year, evolved from those state emergency rules. How well the new system works remains to be seen, as DPH is still in the process of mailing mandatory registration forms to physicians and other potential generators of medical waste.

What was lost in the media and public attention focused on the problem is that physicians have all along done their best to dispose of waste products, particularly sharps. Improper disposal is in direct con-

flict with what physicians are charged to do, which is preserve individual and public health. In fact, the 1989 emergency rules enacted by DPH on waste disposal were reflective of what most physicians already were doing prior to 1989 without regulations.

The intent of the emergency rules was to ensure proper containerization of wastes. Since the greatest contamination risk to the public is in offices and institutions where the waste is first generated, the rules were designed so that medical waste would be properly containerized for safe absorption into the regular waste stream. Federal rules for tracking this waste once it leaves the generating facility were not adopted in the Michigan legislation because the Michigan Department of Natural Resources already regulates the state's solid waste disposal. The DNR worked closely with DPH in developing Michigan's new law.

Although the new law won't change the current system much in terms of cost and procedures, it will provide a more visible system of accountability. (The biggest change is that physicians, hospitals, and other licensed agencies generating waste must register with the state, pay a registration fee, and develop a medical waste plan to be kept on site and available for review.) This will help physicians carry out their responsibilities more effectively and hopefully reassure the public that waste washups are the exception rather than the rule.

In my opinion, the new law merely formalizes a responsible disposal system that the public didn't realize was already in place for a problem well under control.

Doctor Rowe is chief medical executive, Michigan Department of Public Health.



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References

1. *USP DI Update*, September/October 1988, p 120.
2. *Br J Clin Pharmacol* 1985;20:710-713.
3. *Data on file*, Lilly Research Laboratories.
4. *Scand J Gastroenterol* 1987;22(suppl 136):61-70.
5. *Am J Gastroenterol* 1989;84:769-774.

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Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given

an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H₂-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

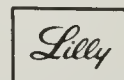
Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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Additional information available to the profession on request.



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Letters from Our Readers

Physicians must be patient advocates first

Patients are a profession's reason for being and they are, or should be, our strongest advocates to correct the deficiencies of our health care system (Croisant, PhD, Victory's Three Ingredients. *Oakland County Med. Soc. Bull.*, 2/90: 3-4).

How unfortunate that most physicians now view their patients as adversaries (Kolta, G., Wariness is replacing the trust between the physician and patient: Both sides talk of a communications breakdown. *New York Times*, 2/20/90; pp. 1, 10). The St. Paul Companies of St. Paul, Minn., the nation's largest medical malpractice insurer, reported 13 claims per 100 physicians in 1989 (30 percent higher than in 1988). From the public's perspective, however, 67 percent feel that doctors are too concerned with making money, keep their patients waiting too long (75 percent), and then spend too little time with them (71 percent), resulting in less respect for the profession than 10 years ago (26 percent). Other major contributing factors needing reform include third party payment systems (e.g. Medicare, Medicaid), which have been accused of destroying patient confidentiality, and creating excess bureaucracy (John G.T., Restoring Trust Between Patient & Doctor, *N Engl J. Med.* 1990; 322:1393-5).

Previous solutions to questions of physicians' supply and distribution have been replaced by increased emphasis on changing medical school student selection processes, physician education programs, limitations of work schedules in training programs, imbursement controls, second opinion programs, and reviews by various interested parties. However, while these solutions are of academic and practical interest, recent legislation has assisted physicians in refocusing their original responsibilities. Specifically, as a matter of law, the patient's health advocate is the physician. The "Wickline decision" (California Court of Appeals, 7/3/86), has found the third party payer to be "absolved from liability...as a matter of law," because the attending physician decides

the course of medically necessary treatment. If physicians are called upon to perform "independent medical evaluations" at the request of a third party, then the physician "owes a duty to care" for the patient even in the absence of treatment (Bridges, B. Metro Industrial Clinic, P.C., Slip Op. No. 86575, 6/5/87; Bolton, V. Jones, 156 Mich App. 642 Slip Op No. 84364, 12/15/86).

The improvement in the physician's image has been established as one of the AMA goals, and in Michigan, the Michigan State Medical Society leadership has established its own plan for "improving Michigan's health care system" (Paxton, R.E., Adelman, S.H., "Building a better health care system for Michigan physicians will play a key role." *Michigan Medicine*, Mar, 1990, 15-20). If physicians are to overcome "the battered image syndrome" (Paxton, R.E., "The Battered Image Syndrome" - We Can Overcome It." *Michigan Medicine*, Mar, 1990, 50), the most productive approach should endorse patient advocacy "...that our patients' need are the priority" (1990, Mich State Soc. Priorities: Physicians caring today for a healthy tomorrow. Mich. Med. Soc., East Lansing, Mich.).

When physicians put the patient first, access to available health care, and education of the health care consumer will permit a gracious transition to promote consumer responsibility, manage costs, technology, and simultaneously expand the physician's role. Physicians must be the patient's health advocate, first.

S.E. Newman, MD
Southfield

Implementation of CLIA '88 explained

Clinical Laboratory Improvement Amendments of 1988 (CLIA '88), Public Law 100-578, was signed by President Ronald Reagan on October 31, 1988. CLIA '88 requires all laboratories, regardless of location, performing tests on human specimens to meet Federal health

and safety standards and to obtain a Federal Certificate indicating compliance with the standards. Many laboratories which have not been licensed or certified by the State of Michigan and/or the Federal Government will be required to meet CLIA '88 provisions.

Laboratories owned and operated by five or fewer physicians to serve their own patients are exempt from licensure under the Michigan Public Health Code. These laboratories will now be required to meet the Federal Standards.

The projected date from the implementation of CLIA '88 has not been established due to the delay in the rulemaking process. CLIA '88 will require five separate sets of rules; and each set will be subject to distinct rulemaking. It was projected that the first set of rules was to be published in the *Federal Register*, April, 1990. This deadline was not met.

The first set of Rules will address certification requirements based upon the complexity of testing and the personnel qualification requirements for each level of testing. The rules for the test complexity model have generated many comments and perhaps will receive more discussion than any of the remaining four.

Whenever the Rules are published, there will be a 90 day period for public comments. These comments will be reviewed; final rules will be written and again published in the *Federal Register* with a 60-day comment period before implementation. Therefore, an unofficial projection is that implementation of CLIA '88 may occur in July, 1991.

The Laboratory Improvement Division, Michigan Department of Public Health, will answer inquiries about the implementation of CLIA '88 and provide information as it is received from the Health Care Financing Administration, Department of Health and Human Services. Please submit your inquiries in writing to the Laboratory Improvement Division, 3500 North Logan St., P.O. Box 30035, Lansing, Michigan 48909.

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MEDICAL NEWSFRONTS

INDEX

Estrogen therapy may be in order for young women with low bone mass, U-M reports 9

Harper/WSU receive multimillion dollar cancer research grant 9

Henry Ford researchers zero in on causes of migraine 9

U-M receives nation's only NIH gene therapy project grant 10

Smokers more likely to die following a heart attack, Henry Ford reports 10

Three Michigan hospitals now offer mobile lithotripter 11

Caffeine does not increase fat-burning potential of walking, WSU reports 11

MSU receives grant to help provide breast cancer screening for rural women 11

Women experience more stress than men if a couple is infertile, U-M study reveals 11

Harper Hospital receives grant to help indigent patients 12

SAFE KIDS coalition works to amend plumbing codes 12

Estrogen therapy may be in order for young women with low bone mass, U-M reports

Lower estrogen levels in healthy young women may be an early warning sign of osteoporosis (loss of bone tissue), according to a new University of Michigan study.

"Our findings are preliminary, but if future studies are consistent with these findings, estrogen therapy well before menopause may prove to be appropriate for women between the ages of 20 and 40 who have lower levels of this hormone," said MaryFran R. Sowers, assistant professor of epidemiology at the U-M School of Public Health.

Researchers have known for some time that low estrogen in postmenopausal women is related to low bone mass and osteoporosis, but the U-M study is the first to report the impact of low estrogen on the bones of otherwise healthy young women.

"The best prevention of osteoporosis in later life appears to be developing peak bone mass through adequate

hormonal status and nutrition when women are in their 20's and 30's," she added.

The study, which has been accepted for publication by Calcified Tissue International, was conducted by Sowers and Brahm Shapiro, professor of internal medicine at the U-M Medical School.

Harper/WSU receive multimillion dollar cancer research grant

Harper Hospital/Wayne State University (WSU), have received two grants from the National Cancer Institute which total \$6.5 million to identify drugs that may be active in treating cancer patients who have solid tumors.

Larry Baker, DO, director, Division of Hematology/Oncology, Wayne State University/Harper-Grace Hospitals, and director, Meyer L. Prentis Comprehensive Cancer Center of Metropolitan Detroit, is the principal investigator for a \$2.5 million grant aimed at identifying

anti-cancer agents which have shown promise in laboratory research and are now being tested in clinical trials with patients.

Fred Valeriote, PhD, deputy director of hematology/oncology at Harper Hospital, together with Thomas Corbett, PhD, professor of internal medicine at Wayne State University, also received a \$4 million grant to test marine extracts from the University of Hawaii and screen them in the drug discovery laboratories of Harper Hospital/Wayne State University.

The Harper Hospital/WSU drug discovery program began in 1983. Since that time approximately 15,000 potential cancer-killing compounds have been screened. According to Doctor Valeriote, the drug discovery program is the largest hospital program that screens anti-cancer agents in the United States.

The drug discovery program also has been instrumental in taking a new approach in screening potential cancer-killing compounds by using tumor and normal cells in a special tissue culture system. Until the late 1980's the National Cancer Institute and other major drug laboratories have screened anti-cancer agents on leukemia cells in mice only and not malignant solid tumors. Since solid tumors comprise about 85 percent of all cancers in this country, this new approach in testing drugs not only focuses on the major cancers but also is more efficient, cost effective and eliminates unnecessary animal testing.

Henry Ford researchers zero in on causes of migraine

An award-winning study at Henry Ford Hospital recently

discovered that too little magnesium in the brain may play a major role in causing migraine.

"Although everyone has the potential to suffer a migraine at some point during their life, about 10 percent of the population has a much lower threshold at which an attack is apt to occur," according to K.M.A. Welch, MD, chairman Department of Neurology, Henry Ford Hospital, and president, International Headache Society.

Perhaps because of a genetic quirk, many chronic migraine sufferers have oversensitive brain cells, which can shift erratically from huge bursts of activity to dormancy. Using the highly sophisticated technique of magnetoencephalography, Henry Ford Hospital researchers were the first in the world to discover these abnormally large bursts of electrical activity coming from nerve cells in the brains of migraine sufferers. Called neuronal hyperexcitability, researchers consider this condition to be one of the primary factors that lowers a person's threshold for migraine.

In their most recent research, investigations found preliminary evidence to suggest magnesium may have a calming effect on these overactive nerve cells. Using NMR spectroscopy, they found that migraine patients have abnormally low levels of magnesium in their brain cells.

"A shortage of magnesium could be what makes nerve cells more apt to fire off," said Doctor Welch. These findings were published in a recent issue of *Headache Journal* and won the prestigious Harold G. Wolff Award.

Investigators are currently developing a follow-up study aimed at determining whether treatment to supplement magnesium will effectively

Continued on page 10

Continued from previous page

prevent migraine attacks. However, Doctor Welch warns against migraine sufferers trying to use extra magnesium as a home remedy. Magnesium supplements can result in some very unpleasant side effects.

U-M receives nation's only NIH gene therapy project grant

The nation's only program project for gene therapy has been established at the University of Michigan Medical Center under a five-year, \$5 million grant from the National Institutes of Health (NIH). The grant, Experimental Models of Gene Therapy, began May 1.

This ground-breaking grant will enable researchers to develop experimental models of gene therapy prior to the application of this revolutionary technology to the treatment of human disease.

The program centers on the development of models of gene therapy utilizing retroviruses and plasmids to transfer genes of therapeutic interest into a variety of organs, both in tissue culture and animals.

While researchers may not be ready to introduce genetic material into human patients at the end of the five-year grant, they are hopeful that they can verify the usefulness of the gene therapy approach.

Principal investigator Francis S. Collins, MD, PhD, U-M associate professor of internal medicine and human genetics and associate investigator in the Howard Hughes Medical Institute (HHMI), said the grant will enable researchers at the University of Michigan Medical Center to take strides toward the actual treatment of genetic diseases.

Three major research projects and four core laboratories are funded by the grant. The major projects will investigate ways of introducing

genetic material into various organs and tissues. The grant also funds three development and feasibility projects — two-year pilot studies designed to provide incentives to scientists in other areas to explore innovative research in gene therapy.

Smokers more likely to die following a heart attack, Henry Ford reports

A new study has confirmed that smokers who don't kick the habit are playing with fire.

"Smokers have heart attacks at an earlier age and are less likely to survive them than a nonsmoker," according to Syed Jafri, MD, of the Division of Cardiovascular Medicine at Henry Ford Hospital.

In a study published in the *American Journal of Cardiology*, Doctor Jafri and his colleagues reported on their two-year analysis of the smoking habits of more than 3,000 heart attack patients as part of the Beta Blocker Heart Attack Trial.

The investigators discovered that cigarette smokers were, on average, about five years younger when they suffered a heart attack than patients who didn't smoke. They reported that 11 percent of patients who were smokers at the time they had a heart attack died within two years following their heart attack compared to eight percent of nonsmokers. In addition, they found that 21 percent of smokers die within two years following a heart attack if they continue to smoke.

The study also found, however, that taking the beta blocker drug propranolol helps reduce the chance those die-hard smokers will be burned by their habit. Smokers in the study who received the drug had a 32 percent lower mortality rate than smokers who received placebos (sugar pills). But even with the benefit from

Continued on page 11

Physicians in the News

John Hickner, MD, associate professor, MSU College of Human Medicine, Escanaba, has completed a six-month sabbatical at the University of Newcastle in Australia. He studied biostatistics and epidemiology and researched rural health practices.

William E. Sprague, MD, a Grand Rapids, obstetrician/gynecologist, is recipient of the 1990 Service Award from the National Council for International Health. The award recognizes an individual who has made an outstanding contribution to international health. Doctor Sprague has served as a volunteer and short-term staff at various places throughout the world.

Ratnaker K. Kini, MD, a pediatric hematologist/oncologist at Mt. Carmel Mercy Hospital, Detroit, is one of 12 recipients of an international award recognizing distinguished achievement and contributions to India's development. The Vinaya Rattna Award is given by the India International Friendship Society, whose members include scholars, writers, journalists, social workers and other public persons dedicated to world peace through international understanding. The award honors Doctor Kini for his work in enhancing Indo-American relations in Washington, DC, by lobbying for the Indian Embassy and for his efforts to set up hospitals and community health care for children in India.

Alexander J. Walt, MD, professor of surgery, Wayne State University School of Medicine, is first vice president of the American Surgical Association. Doctor Walt is the first Detroit physician to

be elected to this position since Theodore McGraw, MD, (one of the Founders of Harper Hospital) in 1896, and the second Michigan physician to hold office since the ASA was founded in 1880.

Peter Winston, MD, a diagnostic radiologist at The Detroit Medical Center, is the new chairman of DMC's Woodland Medical Group Joint Management Committee. The committee has responsibility for the administrative, financial and medical operations of Woodland. Doctor Winston has been on the staff of Woodland since 1980.

Robert W. Black, MD, a Detroit internist, has been reelected vice chairperson of the Board of Directors, Blue Cross and Blue Shield of Michigan. Doctor Black is a member of the MSMS Board of Directors.

Stephen Burton, MD, of Flint, and **Maury Ellenberg, MD**, of Detroit, have been awarded technical assistance grants of up to \$5,000 to study back-related injuries by the Michigan Health Care Education and Research Foundation (MHCERF), the research and philanthropic affiliate of Blue Cross and Blue Shield of Michigan. Doctor Burton, of Hurley Medical Center, Flint, was awarded a MHCERF grant to develop a research proposal on how electrical stimulation may prevent or reverse osteoporosis in spinal cord injured patients. Doctor Ellenberg, of the Department of Rehabilitation Medicine at Sinai Hospital, Detroit, was awarded a MHCERF grant to develop a study of the treatment of pinched nerves caused by herniated discs.

Continued from previous page

propranolol, smokers were still 1.6 times more likely to die after a heart attack than nonsmokers.

"This study clearly shows that smoking is a major risk factor for heart disease. Every effort should be made to help people stop smoking both before and after they develop heart disease," Doctor Jafri said.

Three Michigan hospitals now offer mobile lithotripter

An investigative program, using a mobile biliary lithotripter for treatment of gallstones, began this spring at three Michigan hospitals. St. Joseph Mercy Hospital - Pontiac, St. Mary's Hospital - Grand Rapids and St. Joseph Mercy Hospital - Ann Arbor are among only 11 hospitals nationwide offering the service to qualified patients. The investigational protocol is approved by the Food and Drug Administration and sponsored by EDAP International Corp., the unit's manufacturer.

As with earlier forms of lithotripsy, this treatment is non invasive, and may be an alternative to surgery for select patients. An advantage over earlier forms of lithotripsy is that patients need not be submersed in a bath and may require little or no anesthesia. The device delivers shock waves to a precise focal point, eroding the stone rather than exploding it.

The mobile lithotripter will divide its time between the three hospitals.

Caffeine does not increase fat-burning potential of walking, WSU reports

Downing a few cups of coffee may help keep you

awake during your exercise period, but don't expect the increase in wakefulness to lead to additional weight loss.

That's the conclusion of a study recently completed by Hermann-Josef Engels, an assistant professor in WSU's health and physical education department since last August.

The study recently comprised Engels' doctoral project at Florida State University and focused on whether eight otherwise sedentary men burned more calories when walking after ingesting caffeine than they did if they consumed no caffeine.

In separate tests, the men walked at normal speeds and fast speeds for a period of one hour. An hour before some of the walks, the men consumed the equivalent of three to four cups of coffee in a non-caloric drink. At other times the beverages were caffeine free.

Subjects ingesting caffeine showed no significant increase in fat utilization, Engels said, adding, "The bottom line is that caffeine does not enhance the fat-reducing potential of walking exercise."

MSU receives grant to help provide breast cancer screening for rural women

A \$60,000 grant from the American Cancer Society (ACS) will help Michigan State University provide breast cancer screening for women of rural Michigan.

The grant to MSU's Comprehensive Breast Cancer Center will be used to bring women from rural parts of Michigan, who often don't have access to breast cancer screening, to the MSU Clinical Center.

"The grant will be used to provide transportation to campus," said G. Marie Swanson, director of the Comprehensive Breast Center. "It also will enable the Department of Radiology to

provide mammography for the women participating in the program."

The women, who will be on campus for several hours, will also be provided with a general education program that will deal with cancer prevention and screening.

A major goal of the Comprehensive Breast Cancer Center is to provide service to rural women whose limited access to primary health care and need for education regarding cancer leads to a high mortality rate.

Swanson said the ACS-funded program, which will probably begin in September, will serve as a model which can eventually be incorporated into MSU's community programs.

Women experience more stress than men if a couple is infertile, U-M study reveals

Although both husbands and wives experience stress associated with infertility, the negative impact is stronger on women than men, according to a University of Michigan study. Support from the spouse and from others, however, can reduce the stress and ease marital conflicts.

"Many women have been socialized to feel that bearing children is central to their identity or cultural role, so they feel personally inadequate and unfulfilled if they can't have children. They often feel left out of the mothers' "in-group," according to U-M researchers Frank M. Andrews, Antonia D. Abbey and L. Jill Halman.

Women's attitudes about their sexual attractiveness and performance also are more likely to be affected than men's, they added.

"And regardless of which spouse is infertile, the majority of the fertility tests and treatments focus on the woman's body," the researchers

pointed out. "She is the one who takes her temperature each morning, attends to her cyclical changes each month and confronts the depressing evidence of failure when menstruation begins."

Also, they added, "people typically assume that infertility is the woman's fault and this adds to the social stigma of being childless." Men, on the other hand, may not suffer as much because their primary identities may be tied up in their jobs and earnings.

The study is examining 275 white, middle-class couples over a three-year period. About 60 percent were selected because they were being treated for infertility. The others were presumed to be fertile and served as a comparison group.

Both men and women being treated for infertility said they received a great deal of support from their spouses, and there was a strong correlation between how much support a spouse gave and how much was received. Women, however, said they felt they gave more support than their husbands did, while their husbands reported they both initiated and were the target of more conflict than their wives.

The upshot was, the U-M researchers noted, that many of the men, helped less by outside support, relied heavily on their wives for self-esteem and affirmation while many of the women, who felt burdened with more emotional responsibility, may have become frustrated, exhausted and irritable.

In contrast to some studies conducted in the early 1980's which reported that infertile couples believed other people often were insensitive to their emotional pain, the U-M study found that infertile couples were moderately satisfied with the social support they received from others.

Ninety-six percent of the women and 88 percent of the men had discussed their infertility problem with at least

Continued on page 12

Continued from page 11

one family member or friend in the past year, and both women and men reported that the discussions with outsiders helped them feel somewhat better. Women, however, were much more likely than men to cite both positive and negative reactions to these conversations.

Harper Hospital receives grant to help indigent patients

Harper Hospital in The Detroit Medical Center has received a grant of \$8,225 from the Buhl Memorial Endowment Fund of the Community Foundation for Southeastern Michigan. The grant provides support to indigent patients through the Discharge Planning and Home Care Assistance Program. This program helps provide support to cover items such as pharmaceuticals, food, transportation and equipment to indigent patients who cannot otherwise afford the services when they are released from the hospital.

The Community Foundation for Southeastern Michigan is built around a concept which originated over 75 years ago. It is a permanent community endowment built by gifts from hundreds of community-minded citizens and organizations who are committed to the future of Southeastern Michigan.

SAFE KIDS coalition works to amend plumbing codes

The Detroit SAFE KIDS Coalition and Children's Hospital of Michigan are calling for a change in US plumbing codes in an effort to reduce bathtub scald burns to children. Amendment of the codes would require

developers and landlords to install fixtures that protect people, especially children, from being scalded by tap water in their own home.

"Right now, plumbing valves installed in bathtubs and showers are not adequately regulated," said Pat Vranesich, patient/parent educator at Children's Hospital of Michigan. "As a result, developers and landlords are free to install devices that leave many people at risk for burn injuries, due to their inability to control high water temperatures or regulate the water pressure properly."

Each year, approximately one million American children sustain burns serious enough to require medical attention. Last year, more than 5,000 children were treated in emergency rooms for tap water scalds. In 1989, 69 percent of the admissions to the Children's Hospital of Michigan Burn Center resulted from scald burns. At 140 degrees, it takes only three seconds for a child to receive a severe burn.

"Because of these startling statistics, our coalition and Children's Hospital of Michigan is devoting 1990 to preventing childhood burns from scalds and from residential fires," said Vranesich. "Amending the plumbing codes in our region will help prevent these devastating injuries from occurring."

Children living in low-income housing or in large multi-family apartment buildings are the most frequent victims of severe tap water burns.

The Detroit SAFE KIDS Coalition is part of the National SAFE KIDS Campaign, a long-term effort to prevent childhood injury — the number one killer of children. ■

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ENVIRONMENTAL HEALTH

Physicians Must Get Involved



Physicians' concern about the environment, and human health effects of environmental hazards, was strongly evident at the 1990 MSMS House of Delegates. MSMS members acted on several resolutions urging Michigan physicians to become leaders in responding to major environmental concerns.

This month, the MSMS Board of Directors will appoint a Task Force on the Environment, following the mandate of the House of Delegates that MSMS establish a focal point for coordinating environmental activities. MSMS members have responded enthusiastically to the creation of the new Task Force by the House of Delegates.

Other environmental issues addressed at the 1990 meeting include radioactive waste storage, medical waste disposal and recycling. Delegates called upon MSMS to review and make recommendations on Michigan's participation in the low-level radioactive waste disposal compact, the effects of radioactive waste storage on the environment and public health, the need for revisions to state and federal laws governing radioactive waste and the disposal needs of physicians and health facilities generating radioactive waste for medical purposes. Study of these issues will be among the first priorities of the newly-created Task Force on the Environment.

New regulations governing the handling and disposal of infectious medical waste were reviewed by the delegates, who asked that MSMS work cooperatively with the Michigan Hospital Association to examine the costs of complying with the new law.

Finally, the delegates moved to make MSMS a leader in efforts to encourage recycling of paper products, by initiating a recycling program. The resolution adopted by the House of Delegates calls upon MSMS to recycle paper and purchase recycled paper whenever possible, and to demonstrate its commitment to recycling by including a "recycled paper" logo on MSMS stationery.

Because of these actions taken by the MSMS House, environmental health is the subject of this month's cover story. Included in this cover story is a report from the Michigan Council on Environmental Quality; an explanation of Michigan's Medical Waste Regulatory Act of 1990; an examination of the impact of low level radioactive waste on medical care; a review of a proposal by the Genesee County Medical Society regarding low level radioactive waste; and finally, a message from MSMS President Susan H. Adelman, MD. 

ENVIRONMENTAL PROTECTION:

The Human Health Decision

Michigan's Council on Environmental Quality
Addresses the Link Between Air, Water, Land — and People

By Elizabeth Harris

Earth Day, 1970: Nationwide rallies feature protests against dying lakes, smoggy air, urban sprawl. States and the federal government respond by creating and expanding new environmental agencies to clean up the despoiled environment.

Earth Day, 1990: International demonstrations address the global dimensions of environmental problems that put the Earth's ozone layer, breathable air, oceans, lakes and streams — and human health and survival — at risk.

Will the states, the federal government, and other nations respond by turning new attention to the protection of people from environmental degradation?

In Michigan, the answer already is "yes."

The formal state recognition of a renewed emphasis on human health as a basis for environmental protection comes with the creation of the Michigan Council on Environmental Quality (CEQ) by Governor James J. Blanchard in 1989. Housed within the Michigan Department of Public Health (MDPH) and strongly supported by State Health Director Raj Wiener, CEQ is a revolutionary attempt by government to treat the environment as the sum of its parts — and not as parts alone.

In its first months of operation, the Council has attempted to promote far-ranging discussions among all the elements of society with an interest in a clean, healthful environment. Our message is simple: we believe protection of human health can be strengthened in state, federal and international policy without detracting from the important mission of defending the beauty and quality of our natural resources for their own sake.

A historical perspective

A quick history of environmental protection demonstrates that we have come

full circle in a century. This nation's original response to pollution in the late 1800s was stimulated by the direct threat of raw sewage and other wastes to human health. Later, in the 1940s and 1950s, a series of air pollution episodes that took human life here and abroad focused new attention on pollution control.

By the 1960s, almost all of the waste management and pollution control programs in Michigan were housed in public health agencies. Today, the Michigan Air Pollution Commission is chaired by a representative of the state health department as an historic outgrowth of that system.

Then Earth Day One intervened.

Looking back at the literature of the time, it is possible to find the seeds of what was to sprout from this unprecedented national demonstration of public concern about the environment. While the public expressed some concern about the survival of the human population in the face of mounting pollution, the underlying emphasis of the time was on the environment separate from man, not as man's habitat.

Such thinking resulted in the creation of the US Environmental Protection Agency and the transfer of pollution control authority from the state health department to the Michigan Department of Natural Resources. The approach worked for both the environment and for people. Lead levels in air have declined 90 percent, for example. The banning of toxic chemicals like PCBs and DDT have resulted in declines of 60 to 80 percent in the levels of these contaminants in Lake Michigan fish over the last 15 years, reducing exposure to health risks for the humans who eat them.

A limited approach

But many of us active in environmental protection have been nagged by the feeling that the approach has had limits. By artificially dividing natural resources from

the people who enjoy them and nevertheless pollute them, we have often treated symptoms instead of problems.

While we are spending \$70 billion per year in sophisticated technologies to control pollution at the end of the pipe or smokestack, we are failing to change the human thinking that causes pollution in the first place. Only 20 years after the first Earth Day are agencies and the public beginning to address the real problem — wasteful habits that make large amounts of pollution inevitable. It is invariably cheaper and poses less risk to human health to prevent pollution than to treat it or clean it up.

Similarly, by measuring levels of contaminants in the environment as phenomena in themselves — rather than the possible effects of such pollution on the health and welfare of our people — we may be diverting attention from serious problems that reduce quality of life.

The opportunity presented by Earth Day 20 to reflect on how far we have come and how far we have yet to travel is one Michigan has not missed. From the human health perspective, it appears we must renew our attention to the subtle effects of chronic exposure to low levels of pollutants on people, especially children, expectant mothers, and the elderly.

That's where the new CEQ enters the scene.

Composed of 13 members appointed by the Governor, including the directors of four state departments and nine public members with expertise in fields ranging from medicine to agriculture, CEQ has been charged with analyzing and reporting on the state of our environment. Our role as an advisor to the Governor on long-range environmental health problems and an agency coordinator of policies on the environment has placed us in a unique position to do for the environment what couldn't be done for Humpty Dumpty — to put it back together again. We have done so by developing two important new documents designed to generate discussion and reaction among Michigan's population.

A vision for the future

Our environmental vision statement for the year 2010, CEQ's first major document, sketches our hopes for attaining the most healthful environment among the 50 states. It begins with a recognition of the human role in guarding our natural resources:

"CEQ envisions that in the year 2010...healthy and sustainable natural re-

sources are viewed by all people as essential to sustain human life and other living things, and to enhance the quality of that life...(and that) all Michigan residents understand, accept, and practice environmental stewardship based on a statewide code of ethics."

It is striking that in our first public expression, Council members who often clash on specific environmental issues quickly agreed that it will take a change in human behavior, not the creation of more pollution control programs or the spending of more money, to deliver the environment we want and deserve 20 years from now. Perhaps that bodes well for future efforts here and elsewhere, not just to put the environment back together again in government policy, but to put the public consensus back together again behind strong measures to protect our resource base.

A report on the environment

CEQ's second major document is our 1990 *State of the Environment Report*. Delivered to the Governor just prior to the Earth Day 20 celebration year, the report sets forth progress Michigan has made since the first Earth Day, assesses problems, and puts forward 53 recommendations for future action to achieve our environmental vision for the year 2010.

Its most important finding: "We have been willing to pay for our mistakes. We are only now beginning to *learn* from them...Continued progress will only be possible to the degree that we are willing to cooperatively re-examine and change the relation of our lives and economic activities to the natural world."

Setting forth from this premise, the report notes growing scientific concern about the implications for human health of problems observed in fish and wildlife populations. Tumors in fish and reproductive problems in wildlife species chronically exposed to chemical contaminants are brewing new interest in examining the effect of similar exposures on people.

A controversial study conducted at Wayne State University found that children of women who consumed Lake Michigan fish containing chemical contaminants had lower birth weights and various behavioral differences when compared to children of women who ate little or no Lake Michigan fish.

"...The observations in wildlife and corroborating evidence from other human studies suggest a need for more complete investigation of behavioral, developmental, metabolic, and immunological prob-

lems in children and other populations exposed to certain types of chemicals," the report contends.

Fortunately, as in other areas, Michigan has demonstrated historic leadership in scientifically addressing the issues of chemical exposures and human health. For more than 10 years, the state health department has been conducting long-range epidemiological studies on the effect of the chemical compounds PBB and PCB on Michigan residents. These studies are now reaching maturity and should yield important information on this critical human health issue in the coming years.

But we must do even more. State Health Director Wiener has shown commendable interest in this area, calling for a Great Lakes regional conference to develop recommendations on both necessary scientific research and protective new policies. Both as a member of CEQ and in her agency role, Wiener has fought to concentrate our attention on the potential risks to our most vulnerable citizens — kids — from pollution in the environment.

CEQ also supports Wiener's emphasis on developing new partnerships, rather than renewing old rivalries, to face the environmental problems of the 1990s. As

she said recently in addressing my organization, the East Michigan Environmental Action Council, "Putting Earth Day into action doesn't mean jockeying for position or trying to take the lead away from other agencies or other elements of society. It means, wherever possible, working together for the good of ourselves and the Earth."

That's why CEQ believes new attention to the human health dimension of environmental protection should unite, not divide us. We do not need to invent new agencies or reshuffle programs to address our growing understanding of the complexity of the interrelationships between human beings and their environment. We need, instead, better coordination and communication between existing agencies and programs, and with the public — including medical practitioners.

It is our hope at CEQ to drive new efforts of a united Michigan public to face and reduce environmental problems in the 1990s and beyond. The problem begins and ends with people. The solution — and our survival — depends on us. ■

Elizabeth Harris is chairperson of the Michigan Council on Environmental Quality, MDPH.



AN EXPLANATION of Michigan's Medical Waste Regulatory Act of 1990

By Lawrence Chadzynski, RS, MPH

In the summer of 1988 medical wastes were found on a number of beaches around the country, including the beaches of Lake Michigan and Lake Erie. Both national and locally publicized coverage of these incidents heightened public concern and aroused fear of disease from possible exposure to contaminated medical waste. As a result, the public sent a clear message to its legislative representatives that they wanted special handling and disposal of medical waste. The continued findings of alleged improper disposal of medical waste further exacerbated public concerns about medical waste disposal practices and necessitated the intervention of public health authorities in Michigan and elsewhere (44

states have either passed medical waste legislation or promulgated new rules or revised rules and regulations).

The new regulations contained in the federal Medical Waste Tracking Act of 1988 and in the Michigan Medical Waste Regulatory Act of 1990 are discussed below.

Federal regulation

In response to the public outrage about medical waste mismanagement, Congress passed the Medical Waste Tracking Act of 1988. The law required the United States Environmental Protection Agency (EPA) to establish a two-year demonstration

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program to track medical waste in 10 states: New York, New Jersey, Connecticut and the seven states bordering the Great Lakes.

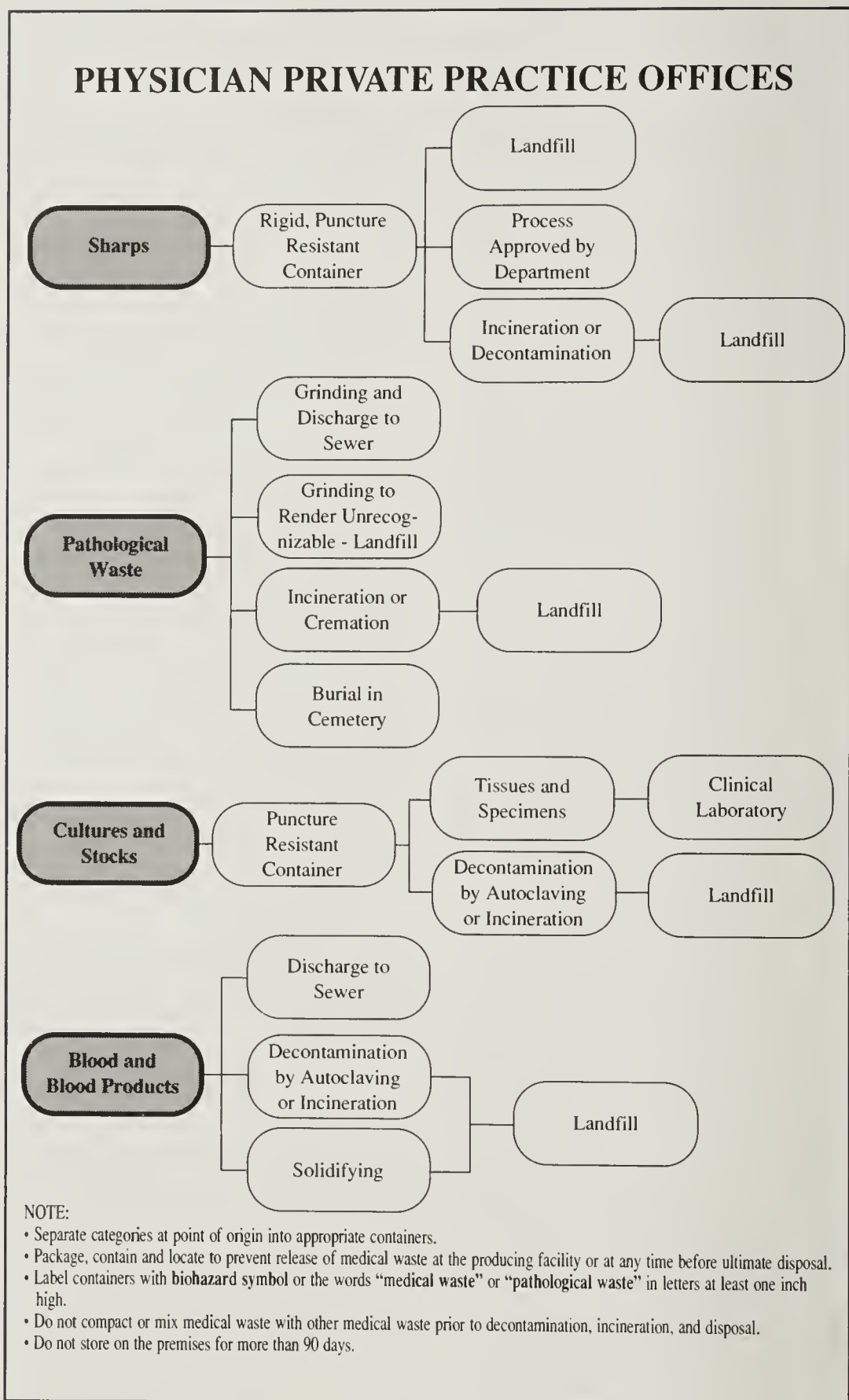
The demonstration program is intended to track 10 different categories of medical wastes from any facility that generates more than 50 pounds of waste per month. This tracking system will add considerable cost to the health care system. At the Management of Medical and Infectious Waste Conference held in Washington, DC, in December of 1988, EPA Deputy Director Jack Moore stated that "the law was passed because of the perception on the part of Congress that something was wrong. The American people simply will not tolerate the improper disposal of syringes, blood, body parts or specimens, in the future. People do not want to see wastes washed up on beaches, and they don't want to find them in dumpsters behind doctor's offices."

State regulation

When Governor James Blanchard chose to opt Michigan out of the federal Medical Waste Tracking Act program, he directed the Department of Public Health to promulgate "medical waste emergency rules" to regulate the handling and disposal of medical waste. These rules became effective on April 26, 1989, and represented an interim measure to require generators of medical waste to take the necessary precautions to safeguard the public health.

In March, 1990, a package of seven tie-barred bills crafted by the Michigan Legislature, known collectively as the Medical Waste Regulatory Act of 1990, were signed into law by the Governor, replacing the emergency rules. Key objectives of the Regulatory Act are: (1) to establish a program to regulate the handling and disposal of medical waste to protect the public health by preventing, to the extent possible, public exposure to the risk of injury, infection or disease from improperly disposed infectious medical waste; (2) to alleviate public concern about medical waste mismanagement; and (3) to manage medical waste by methods that should not result in overly burdensome requirements.

The Regulatory Act mandates how producing facilities (generators of medical waste) must handle waste from the point that it becomes medical waste to the point of its ultimate disposal. These regulations require that the producing facilities take certain steps in handling, labeling, pack-



aging, storing, transporting and disposing of the regulated medical waste and to prepare a management plan for such procedures. Regulated medical waste includes cultures and stocks of infectious agents, liquid human and animal wastes, pathological waste, sharps and contaminated waste from animals that have been exposed to agents infectious to humans.

The majority of physician offices generate the sharps category of regulated medical waste, some also generate cultures and stocks and blood and blood products.

Still others may generate pathological waste. The schematic presented at right illustrates disposal methods for physician offices.

It should be noted that materials stained with blood or other body fluids are not included in the Act's definition of regulated medical waste. They can be treated as solid waste for the purpose of final disposal.

The Act considers physician offices which generate any of the five defined cat-

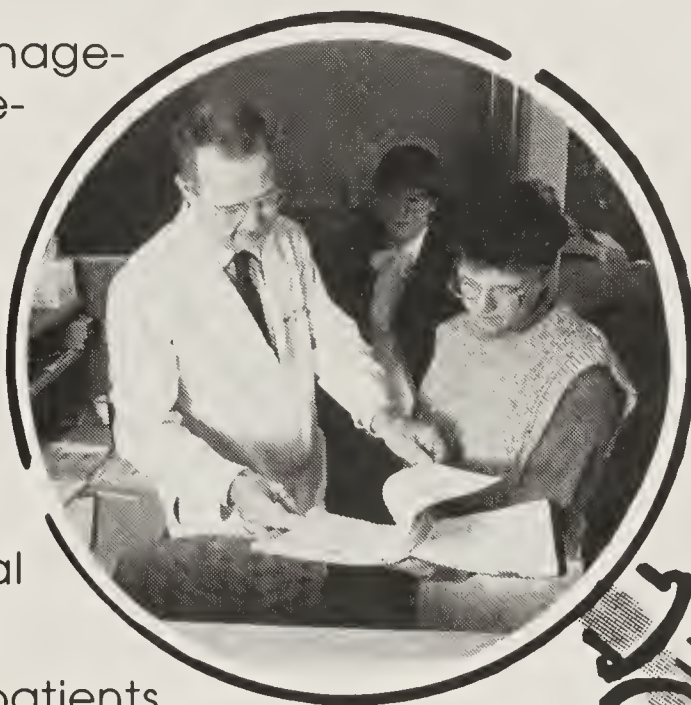
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Producing facilities must separate the categories of medical waste at their point of origin into appropriate, properly labeled containers. Sharps must be placed into rigid, puncture resistant containers. Containers used to collect, store and transport regulated medical waste should be clearly labeled with a "biohazard" symbol or the words "medical waste" or "pathological waste" written in letters at least one inch high. Regulated medical waste cannot be stored on the premises of a producing facility for more than 90 days.

All categories of medical waste must be packaged in a manner that prevents accidental release in the office or at any time before ultimate disposal. Sharps must be

transported for final disposal in a manner that retains the integrity of the sharps container. Sharps shall not be compacted. It's important to note that most refuse removal trucks are equipped with compactors and have the potential to crush the sharps containers and disperse their contents.

The Regulatory Act also requires physician offices which generate any of the categories of regulated medical waste to maintain on their premises a written medical waste management plan. The plan must describe the categories of medical waste handled, how they are handled, stored and disposed of by each producing facility. Additionally, the Act includes a training requirement. Each producing facility must train both its medical and non-medical personnel who handle and dispose of medical waste. Training procedures, methods, materials covered, etc., should be reflected in the written medical waste management plan.

In Michigan, the medical care community has a long history of carefully managing infectious medical wastes within their facilities to control communicable diseases. Nevertheless, concerns have surfaced about health risks posed by medical

waste because of the notoriety of reported incidents of improperly disposed medical waste that led to the promulgation of emergency rules and now permanent statutes.

As the environment reemerges as a national issue, the proper disposal of medical waste remains, at the very least, a highly visible and volatile part of this nation's solid waste crisis. To better develop appropriate controls for dealing with regulated medical waste, we will need to work together. Journal articles such as this provide an important opportunity to share and move forward our understanding of this problem so that we may all enjoy a safer and better environment.

Proper handling and disposal of medical waste will remain a public issue as long as wastes believed to be of medical origin are found on beaches or at unauthorized storage or disposal locations. Hence, compliance with the regulations for the handling, storing, treating, transporting and ultimate disposal of regulated medical waste by providers of health care in Michigan must be observed. ■

Lawrence Chadzynski is acting deputy chief, Bureau of Health Facilities, Michigan Department of Public Health.

Sample Plan

A producing facility shall have a written medical waste management plan on file on the premises within 90 days after registration. The medical waste management plan shall contain the following information, to the extent the information is applicable, to the producing facility.

Producing Facility Name: _____

Address: _____

Telephone: _____ Date: _____

Individual Responsible for the Management of Medical Waste:

Types of Medical Waste Handled (check applicable box)

- ☐ 1. Cultures and stocks of infectious agents and associated biologicals, including laboratory waste, biological production wastes, discarded live and attenuated vaccines, culture dishes, and related devices.
- ☐ 2. Liquid human and animal waste, including blood and blood products and body fluids, but not including urine or materials stained with blood or body fluids.
- ☐ 3. "Pathological Waste" means human organs, tissues, body parts other than teeth, products of conception, and fluids removed by trauma or during surgery or autopsy or other medical procedure.
- ☐ 4. "Sharps" means needles, syringes, scalpels, and intravenous tubing with needles attached.
- ☐ 5. Contaminated wastes from animals that have been exposed to agents infectious to humans, these being primarily research animals.

.Describe for each type of medical waste handled, segregation, packaging, labeling, and collection procedures used.

.Describe the use and methods of on-site or off-site storage.

Describe the use and methods of on-site or off-site decontamination.

.Describe the use of on-site or off-site incineration.

.Indicate the corporate or other legally recognized business name of solid waste haulers who transport medical waste for the producing facility.

.Indicate (by name) the use of sanitary landfills, cemeteries, and other disposal sites.

.Describe the measures to minimize exposure of the facility's employees to infectious agents throughout the process of handling and disposing of the medical waste, including, where applicable, the use of protocols, procedures and training, personal protective devices and clothing, physical containment or isolation devices or systems, and prevention or control of aerosols.

It's Important to Note:

- A medical waste management plan shall comply with the requirements of the Medical Waste Regulatory Act.
- A producing facility shall update a medical waste management plan each time there is a *change* in either of the following, within 30 days after the change occurs:
 - a. A person or site named in the plan.
 - b. The type of medical waste handled or the methods of handling medical waste at the facility.
- A producing facility shall comply with its medical waste management plan.
- Upon request, a producing facility shall make its medical waste management plan available to the department.
- Upon receipt of 24 hours' advance notice, a producing facility shall make its medical waste management plan available to an employee of the producing facility for inspection on the premises or provide a copy of the medical waste management plan to the employee.

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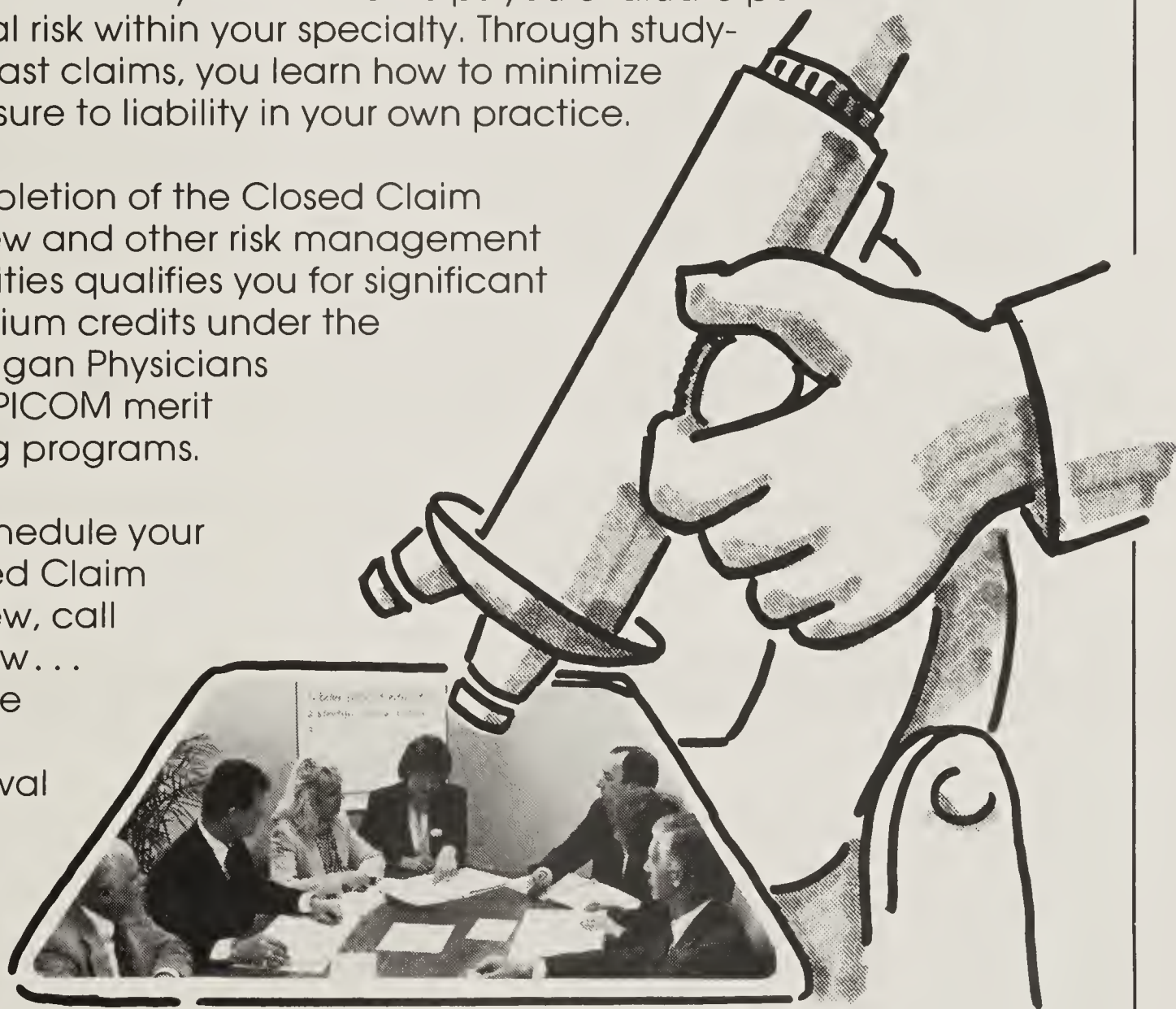
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THE IMPACT

of the low level radioactive waste issue on medical care

By Howard J. Dworkin, MD

How could the State of Michigan's inability to deal with low level radioactive waste (LLW) affect medical services to over 100,000 patients annually? Could the availability of the bone scan — used so frequently to follow patients with malignancy — become unavailable? Where would hyperthyroid patients go for treatment if radioactive iodine could no longer be produced? These questions need to be answered by physicians to avoid a serious potential lapse in medical care looming on the horizon.

Radioactive substances (radionuclides) may be produced in a nuclear reactor similar to the reactors used to make nuclear power. These reactors have as a by-product low level radioactive waste. Although Michigan does not now produce medical radionuclides for commercial sale, it is a large user of such products. Residents in the geographic locale in which the nuclear reactor exists may have the same attitude as those in the Western portion of our state: If the residents of Illinois want to use electric power generated by our nuclear reactors then they must bear a responsibility for a proportion of the LLW.

The most common radionuclide used in nuclear medicine imaging is Technetium 99m (Tc-99m). It is tagged to a host of different pharmaceuticals which have desirable pharmacokinetic behavior. One such group of agents is Tc-99m — labeled Diphosphonates — which accumulate in bone in increased amounts when bony turnover is increased, thus making it possible to detect metastases, bone trauma, and osteomyelitis at an early stage. Tc-99m has a physical half-life of six hours and therefore poses no disposal problem. (The usual rule of thumb is that after 10 half-lives essentially all radioactivity is gone.) The Tc-99m is a decay product of a longer lived parent, Molybdenum 99 (Mo-99), from which it is obtained. The Mo-99, with a half-life of 66 hours, is obtained from a nuclear reactor. Small hospitals purchase Tc-99m in a vial from a supplier who purchases immobilized Mo-99 attached to a column (a generator) from

which the Tc-99m may be washed (eluted) into solution. Large hospitals often purchase the generator itself (which is packed in lead) since this is more economical and more flexible for large users. When the Mo-99 in the generator decays below a critical level, it is no longer useful and thus becomes LLW and is usually returned to the supplier.

A small number of other long-lived radionuclides also are used for nuclear medicine imaging. When they come in contact with bandages, paper and gloves, these items become part of the LLW to be disposed of.

Not all wastes come from imaging procedures. Radioimmunoassay (RIA) procedures often use long-lived materials such as Tritium (half-life-12 years) or radioiodine, I-125 (half-life-60 days) which under certain circumstances must be disposed of. In fact, institutions carrying out research using RIA and tracer methodologies could be those hardest hit if waste disposal were interrupted.

Although the amount of LLW from the medical community is small compared to all other sources (less than one percent), it is vital that provisions be made for its safe and economical disposal. On-site storage is a temporary solution, at best, since most hospitals and universities were never built with the thought that hundreds of square feet of costly space would be used for this purpose.

The answers to the questions posed in the first paragraph are: (1) Medical and research procedures using radionuclides could come to a halt if safe disposal for LLW is not available. (2) The bone scan, and many other medical procedures, could become unavailable if LLW sites are not identified. (3) Hyperthyroid patients would be treated only in those states where adequate provisions had been made for medically-generated LLW.

Once the need for medical LLW disposal is appreciated, the discussion moves to the politics of waste disposal in general. Nobody wants someone else's trash. Some unrealistic souls won't even care for their

own. Everyone wants the benefits.

The medical benefits of radiation are clear; many patients would suffer if such procedures were terminated. One other medical area deserves consideration. We must attempt to contrast the benefits and the risks of radiation. No one will argue that in high "doses" radiation can be dangerous, but so can aspirin and digitalis. How dangerous is radiation? We live in a sea of background radiation (about 0.1 REM/year). In Colorado, the annual background dose is double that in Michigan with no discernable medical effects (e.g. cancer incidence, life shortening, etc.). On average, medical use of radiation exposes our population to a dose equal to background. Included in the radiation dose are common tests such as chest, bone, abdominal, and kidney x-rays. The CT examination is almost a household word as is cardiac catheterization. Undoubtedly, all of these procedures have some risk, but the risk is considered to be small, usually unmeasurable, compared to the benefit. Such procedures are done often enough to be classified not only as a benefit to the individual, but as a benefit to our society. Who has not been touched by their benefit? Benefits from nuclear medicine procedures are equally important and the radiation dose is about the same as the dose received from x-ray examinations. We are not speaking of atomic bombs, we are not speaking of Chernobyls, and we are not speaking of a dose of aspirin equivalent to a box car loaded with aspirin.

As physicians, we can distinguish the difference between the customary therapeutic dose of a drug and a billion times that dose. This sense of reason and scientific discipline must be brought to the LLW issue. The waste disposal sites now being built (fortified warehouses) are a far cry from the dump sites created 40 years ago. They may leak, but the leakage will be less than that of 40 years ago. We are unaware of any deleterious medical effects of leakage even from the more rudimentary early waste disposal sites. Some effects may appear at a later time; nonetheless, we as a society have benefits which have derived directly from the products that produce these wastes.

The residents of the State of Michigan must be responsible citizens if the medical benefits of radioactive materials are to be made available to them. The small risks must also be borne. ■

Doctor Dworkin is director, Department of Nuclear Medicine, William Beaumont Hospital, Royal Oak.



GENESEE COUNTY MEDICAL SOCIETY

Takes a Stand on Low Level Radioactive Waste

By Robert M. Soderstrom, MD

The Genesee County Medical Society sent several delegates to the MSMS Public Affairs/Leadership Conference in Lansing last September. The keynote speaker was the president of the Canadian Medical Association who spoke at length about the practice of medicine in our northern neighbor. At one point during his speech, the president was asked about the public image of physicians in Canada. He stated that he felt it was quite good and when he was asked why, he replied without hesitation that the Canadian Medical Association had a very active environmental committee that regularly took positions on environmental issues and the public's health.

Shortly after that conference, the state of Michigan announced the potential citing of a "low-level" radioactive waste disposal facility in St. Clair County, Lenawee County, or Ontonagon County. As the public outcry over these proposed sites increased, the Genesee County Medical Society appointed an environmental committee with the specific charge to develop a position paper on this issue. With Michigan's environment and the public's health as the primary focus, the newly-appointed Environmental Health Committee registered several concerns and eventually the Genesee County Medical Society adopted a position paper in opposition to the citing of such a waste dump anywhere in Michigan. At the recent MSMS House of Delegates meeting, Genesee County delegates presented their position and the issue was referred to the Board for expeditious review because of its public health significance.

Six reasons for opposition

The reasons for opposition to the site in Michigan are several:

1. The term "low-level" does not mean biologically-low levels of radiation. When

the Nuclear Regulatory Commission speaks of "low-level" waste, they mean all that waste from a nuclear power plant that emits low levels of radiation in comparison to the highly radioactive fuel itself. Thus, by their definition, a non-fuel reactor component emitting 1,000 rads/hour is "low-level," for it is not a high level fuel component. "Low-level" by this terminology means only that the waste to be sent to Michigan from 14 nuclear power plants in the midwest is not the very highly radioactive fuel itself. However, virtually everything else from a nuclear power plant can be sent here and much of it is highly radioactive and long-lived. Highly radioactive components that therefore qualify for a "low-level" waste site include components of the nuclear reactor itself — filters, filter sludge, and various absorptive resins. It is this material that constitutes 85 percent by volume and 99 percent of the long-term radioactivity to be placed in such a dump. While nearly all medical radioactive waste has half-lives of minutes, hours, and days, the radioactive materials from nuclear power plants have half-lives of decades or more.

2. Cesium-137 is a major radioactive contaminant from power plants. Not only does it have a half-life of 30 years, requiring 300 years to decay to insignificant levels, but it is extremely biologically active, being greatly concentrated in the food chain. For this reason, Scandinavian lakes and fish are now significantly contaminated with this isotope because of the Chernobyl disaster, even though the fallout was greatly diluted, having travelled over nearly 2,000 miles. Strontium-90 is another isotope with food chain implications. Strontium-90, ingested from ground contamination, is excreted in cow's milk and thus is ingested by human beings. Either one of these isotopes, escaping into the environment through

land, water, or air contamination, represents a significant public health threat.

3. The Nuclear Regulatory Commission intends to license these landfill facilities for 100 years even though they readily admit that such facilities will be radioactive far beyond 100 years, even beyond 500 years. Such a licensing policy is not responsible.

4. The site is to close after accepting radioactive waste from 14 midwestern power plants over a period of 20 years. The waste management company will remain on site for five more years and then leave. Ownership of and liability for the site then reverts to the people of Michigan. Any problems that occur at the site after 25 years will revert to the taxpayers of Michigan for a solution. Those who have generated the radioactive waste — those very groups who are assuring us right now that these sites will never leak — will be gone from the place, lock, stock, and barrel.

5. No place in the United States has stored radioactive waste without ground or water contamination for even 20 years, let alone 25, 50, 100, or 500 years. A critical point is that three sites in wet environments like Michigan's — in the states of Illinois, Kentucky, and New York — are currently closed and are environmental catastrophes. The estimated clean-up cost for the New York site alone is \$1 billion. Everyone agrees that the sites in arid environments — in Nevada and Washington — have done better, for the lack of precipitation simplifies the storage of radioactive waste.

While there have been many problems associated with the previously failed efforts to store radioactive waste, the major culprit has been water. It is water that eventually seeps into storage vaults. It is water that corrodes storage containers and casks. It is water that carries radionuclides off site. Michigan has this nation's (and the world's!) greatest fresh water resources, the nation's longest coastline and the world's largest fresh water lakes (already seriously contaminated). The state is criss-crossed by streams and rivers and we have a ubiquitous water table a few feet below the surface. Experience shows that Michigan is no place for a "low-level" radioactive waste site.

6. Finally, it needs to be noted that several nations with major nuclear programs already have decided against the use of surface landfills for so-called low-level radioactive waste storage. Great Britain, West Germany, and Sweden have officially

Continued on next page

Continued from previous page

stated that only deep geological repositories are acceptable sites for radioactive waste of the type the Nuclear Regulatory Commission wants to put in a Michigan landfill.

National solution necessary

So what does the Genesee County Medical Society propose? We feel a national solution is required for a national problem; radioactive waste disposal. It is not responsible policy to ignore the lessons of the past and to insist upon radioactive waste disposal in a water-rich environment. The nation should search for one site to contaminate with "low-level" radioactive waste, not 10 or 15 regional sites. Ideally, that site should be in as arid an environment as possible, with water tables as deep and isolated as possible, as far away from people as possible, on land that already has been contaminated with radioactive isotopes, and on non-productive land the federal government already owns. A possible site would be the hundreds of eternally contaminated square miles that make up the Nevada bomb range.

We believe that physicians do have an obligation to speak out on the health implications of environmental policy. It is, after all, the ultimate extension of preventive medicine. We also believe that physicians in Michigan have a responsibility to protect the unique aspects of this state's environment, for its degradation will ultimately affect the people of Michigan the most. We do not deny that the nation has benefited generally from the electricity produced by nuclear power plants, but that fact does not mean Michigan's particularly vulnerable environment should be risked by contamination with long-lived biologically active radioisotopes. We agree emphatically that we have a responsibility to help the nation solve this problem in the *safest* possible way and, as physicians, our paramount concern must be the public's health.

We support and agree with the newly proposed MSMS, C.A.R.I.N.G. Campaign to improve the public perception of physicians, but we would submit that a caring stand on environmental issues of importance to the public will not go unnoticed. Few issues better exemplify the MSMS tagline, "Physicians caring today for a healthy tomorrow." ■

Doctor Soderstrom is chairman, Environmental Health Committee, Genesee County Medical Society.



MSMS SHOULD

*serve as a resource
to environmental agencies*

By Susan H. Adelman, MD

The Michigan Department of Public Health released its *State of the Environment Report*, prepared by the Council on Environmental Quality (CEQ), timed to coincide with Earth Day 1990. The CEQ was appointed by Governor Blanchard, is chaired by Elizabeth Harris, the Executive Director of the East Michigan Environmental Action Council, and it has 12 members. One of these members is a physician — Kenneth Rowe, MD, of Hancock.

The report's recommendations are summarized under 14 major headings, three of which include: *human and ecosystem health, pollution prevention, and human health*. The final heading is: *environmental research, data, and economics*.

What conclusions should we draw from all this? First, that even a committee with only one physician on it recognizes the important link between a healthy environment and human health. Second, that medical expertise is required in multiple areas to help identify specific causative factors for human disease in the environment. Third, that we need more physicians in data collection, research, expert analysis of this data, and dissemination of information about environmental causes of disease. And fourth, that both MSMS and the Department of Public Health need to put the MD back into public health and environmental health.

The cover letter introducing the report has two principal points: 1) It considers "ecosystem and human health as a priority," and 2) That the long-term environmental quality of the state must be considered in all development decisions made by state and local agencies..." So far, so good.

The final recommendations in the human health section are for: 1) The creation of an endowment for long-range epidemiological studies of the effects of pollution exposure on human health; 2) Human health research targeted at the effects of pollution on urban populations, minorities, and the poor, along with the ef-

fects of PCB exposure; 3) Creation of a specimen archive to store human blood and tissue for comparisons of pollutant and chemical levels over time; 4) Development of mapping systems for investigating links between pollutants and possible health effects; 5) Improvements in the air quality program; and 6) Improved communication with the public about health risk issues. This program has many facets in which doctors should be prepared to take the lead.

What role should MSMS play in all this? Our new Task Force on the Environment should serve to focus our energies and priorities in this area. Our drive to identify physicians with specific expertise and interest in those fields of medicine which have either a direct or even a tangential connection to environmental issues should enable us to furnish our medical expertise as a resource to the state or to any other parties interested in improving human health by cleaning up the environment. Our ability to conduct research, collect data, analyze data, and recognize medical applications and implications of this data should prove vital to the success of all the human health proposals recommended by the CEQ.

MSMS communications resources could prove to be immensely helpful to the state as specific recommendations are issued on such matters as consumption advisories for Great Lakes fish, or recommended safe toxic levels for various chemicals. Our involvement sends the message to the Department of Public Health that its potential success will require joining forces with the medical community, so that each can support and strengthen the efforts of the other.

The fact that MSMS and Michigan physicians demonstrate our involvement with environmental health issues and their impact on human health shows the depth of our commitment, first and before anything else, to the health of our patients. ■

Doctor Adelman is MSMS president.

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Professional input was key to developing new Blues' par contract

By James L. Gerardi

Physicians have been finding new Blue Cross and Blue Shield of Michigan (BCBSM) participation contracts in their mail boxes lately — along with an invitation to sign up.

In a recent interview, BCBSM Medical Directors Fred Severyn, MD, and Donald G. Bearden, DO, talked about the contract — officially called, The Physician and Professional Provider Participation Agreement. (It covers podiatrists, chiropractors and psychologists as well as physicians.)

Why a new contract? And why now?

"After 50 years, we're looking for a fresh start with physicians," Doctor Severyn replies. "Health care has changed and our business has changed. It was time to rethink everything we're doing and to bring physicians into policy development in a better way."

Taking another look

Mailing of the contracts in late May capped a process that began in January 1988 when new top management under Richard Whitmer led the Blues in reassessing the company's relations with physicians and other publics.

"The starting point," Doctor Bearden says, "was realizing how much we need the good will and trust of physicians. Part of that process is to put in writing mutual responsibilities.

"We can't deliver benefits to our subscribers if physicians don't participate with us. And if ethical, cost-aware physicians don't support Blue Cross and Blue Shield, we have no leverage to investigate the small percentage who give physicians a bad name."

The old one-page par contract known to two generations of Michigan physicians was no longer adequate, Blues management decided.

"It was basically a registration form with a reimbursement clause," Severyn explains. "It didn't touch any of the issues that have grown up between physicians and BCBSM over the years.

"Utilization review, appeals, payment methodology, and so on have all been administrative matters. We felt the contract would be a good vehicle to eliminate confusion...to let the profession know what we expect in those areas, and what commit-

ments we are prepared to make to physicians. Therefore, much of what is contained in the contract is derived from policies, heretofore not pulled together in one document."

BCBSM is listening

BCBSM decided to set up a physician advisory panel for input to the terms of the new agreement.

"Frankly, we saw the par agreement as a way to start over with physicians," Doctor Bearden says.

At the Blues' request, MSMS and the Michigan Association of Osteopathic Physicians and Surgeons (MAOP&S) appointed members to the advisory panel. In addition, Doctor Bearden, along with other staff medical directors and BCBSM officials, fanned out across the state to get the views of county and specialty society representatives in a series of meetings that stretched over months.

In the early weeks of 1990, the voice of the rank and file was heard at physician focus group seminars held by Blues board members in nine cities.

Doctor Severyn smiles at the memory. "Well, we heard a lot. Let's say the physicians were outspoken. But that's what we wanted. We didn't invite them to have tea," he said.

"They gave us plenty to chew on, and a number of the major points they made coincided with what we'd been hearing at our other meetings and through the professional grapevine. What impressed us at the focus groups was the depth of feeling behind what was said.

"Many of those views were reflected quite directly in the final drafts of the par agreement.

"Physicians have asked us to consider a fixed payment schedule, and that's exactly what we're going to implement September 1, 1990.

"The payment schedule will be printed and made available to physicians at selected locations such as hospitals and society offices. And we're going to review the payment levels every 12 months.

"We've also been asked for a more streamlined appeals process and external peer review. Both are in the agreement.

"There were complaints about our using statistical sampling to recover money

in overpayment cases when medical necessity was at issue between us and the doctor. That's gone. We'll still use sampling in some cases, like miscoding, but we've committed in the agreement not to use it in medical necessity determinations.

"We've written in solid protection for confidentiality of records and a guarantee that non-BCBSM physicians will review and comment on any proposed medical necessity criteria.

"And we're creating permanent physician advisory committees for ongoing input from the profession. The committee will consist of MSMS- and MAOP&S-appointed physicians and BCBSM board members.

"In fact," Doctor Severyn concludes, "this may be the most important change of all, because it means physicians will have a channel for initiating change in the physician contract. The advisory committee will speak on reimbursement, medical necessity, and other policy and administrative matters, including service."

Goal: more par physicians

Seventy-one percent of Michigan physicians participate formally in BCBSM, "but that leaves thousands who don't," Doctor Bearden says, "and we'd like to attract them."

The Blues especially want to increase participation in areas where it's been low, like western Michigan.

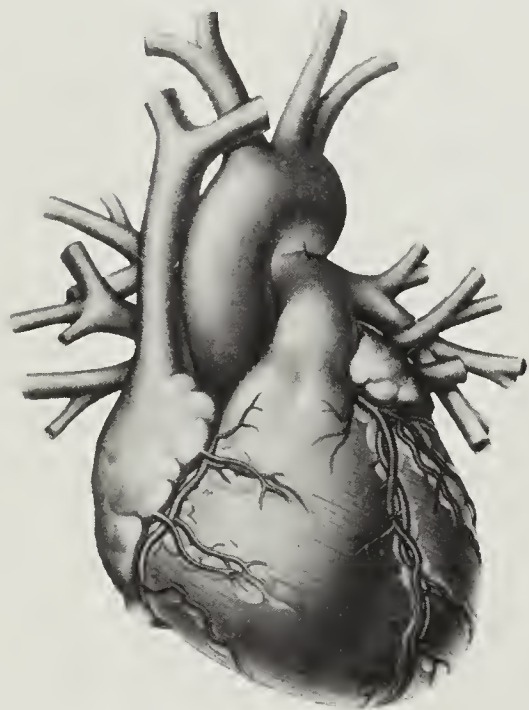
"It's harder for us to market our products in that area without wider participation," Doctor Bearden explains. "And balance is important. We are the Blue plan for all of Michigan and we need to hear the concerns and priorities of the western half of the state.

"In fact, we're after nothing less than a renewed partnership with Michigan physicians. It may sound corny, but it's true. There are a lot of issues out there looming over both of us. Our interests won't always coincide, but we're both better off with good communications and mutual respect.

"That's what this new agreement is about and why we're inviting every physician in Michigan to sign." ■

James Gerardi is executive editor, Corporate Information, BCBSM.

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MSMS

launches resident/mentor campaign



Thomas M. Sullivan, MD (left), and Calvin Schorer, MD (right), helped launch the resident/mentor campaign.

The MSMS Resident/Mentor Campaign is a new membership recruitment effort to ensure that resident physicians will continue to help shape the goals of organized medicine. As future leaders, resident physicians represent the goals needed to meet the challenges of organized medicine.

The campaign was launched when Calvin Schorer, MD, and Thomas M. Sullivan, MD, psychiatrists at Lafayette Clinic, Detroit, sponsored membership dues at the county, state and national levels for 40 residents at Lafayette Clinic and Detroit Psychiatric Center.

Doctor Schorer believes that sponsoring resident membership is an excellent

way to introduce residents to the benefits of organized medicine and to provide the opportunity for them to extend their interests beyond practicing medicine to community affairs and legislative issues.

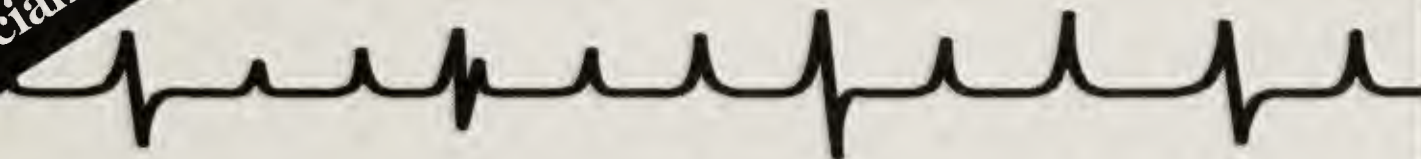
MSMS members are urged to become mentors by:

- Identifying residents to serve as leaders in organized medicine;
- Sponsoring resident membership dues at the county, state and national levels — approximately \$15, \$20 and \$45;
- Submitting their names to the MSMS Resident/Mentor Campaign.

Contact Rose B. Heald at MSMS to request an MSMS Resident/Mentor Campaign packet. ■

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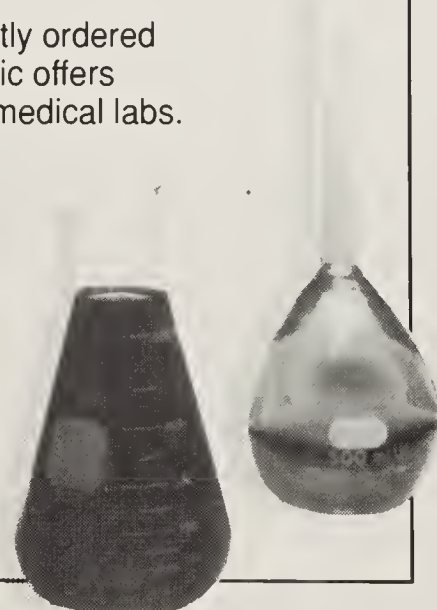
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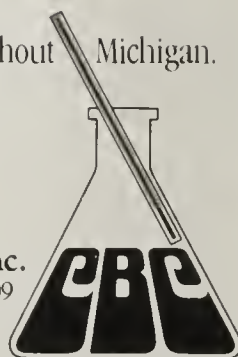
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Please see references and a brief summary of prescribing information on adjoining page.

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In mild to moderate hypertension

*Lower initial doses of 120 mg a day may be warranted in patients who have an increased response to verapamil (eg, the elderly or those of small stature).

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring.

Decreased metoprolol clearance may occur with combined use. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, increased urination, spotty menstruation, impotence.

12/21/89 • P90-W198V

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7. Data on file, G.D. Searle & Co.

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Genesee County Medical Society Auxiliary

launches human sexuality education center

By Judy McLeod



Visitors study the human sexuality exhibit at the Sloan Museum.

In 1986, the Genesee County Medical Society Auxiliary voted to develop the concept of a "Human Sexuality Education Center" in honor of the organization's 50th anniversary. On March 28, 1990, the center became a reality.

This education and resource center, a joint effort involving the Sloan Museum and the Auxiliary, is housed in the museum's Health/Science gallery. The uniqueness of this center is that it focuses entirely on the topic of sexuality, in particular, three main aspects of sexuality – reproduction, relationships and responsibility. The center is titled – "Human sexuality, understanding ourselves and our relationships."

Many factors motivated the Auxiliary to pursue the idea of a human sexuality center. In Genesee County teen pregnancy and infant mortality are above the state and national averages, and sexually transmitted diseases are on the increase. Surveys show that even in today's open society teens still have many misconceptions and lack accurate knowledge to make good decisions about their sexuality. With these factors in mind, the Auxiliary set out to help meet a community need and to augment existing school and community

educational programs.

The center is designed for all age groups. It accommodates school children in a classroom setting as well as touring individuals and families visiting the museum. It's anticipated that 60,000 school children and 130,000 visitors will tour the museum annually.

As one enters the center, four three-sided kiosks encompass the central section of the room. These kiosks illustrate in different designs and methods the following subject matter: male and female sexual anatomy, conception, sexually transmitted diseases, contraceptive information with devices, population trends, cost of raising a child in today's society, a pregnancy apron with a mirror to show what it looks like to be pregnant and a thought-provoking relationship exhibit. One large wall is designed to present conception through birth and delivery. This exhibit contains several large fetal photos and a push-button narrative tape describes the process from conception to birth. A second wall exhibit is a back-lit cartoon design depicting the stages of life from infancy through the senior years. The back wall is a collage of large-sized people photos which project a feeling of love, caring and respect to

the entire center and its subject matter.

The Genesee County Medical Society strongly supported this project, financially and philosophically. Seventy-two thousand dollars of the \$80,000 goal was funded from a variety of community sources. These funding sources included foundations, health care organizations, community groups, government, businesses, the medical community and, of course, the Medical Society and Auxiliary. Further monies will allow for the development of a video component, more materials and increased curriculum.

This is a permanent exhibit which will be marketed the way Sloan Museum markets its other projects. Schools, youth groups, Boy Scouts, Girl Scouts, and church youth groups will be contacted and encouraged to visit the center.

We know this Human Sexuality Education Center will be an asset to our community and surrounding areas. It is imperative that our young people are given the facts necessary for making intelligent decisions about managing their sexuality. ■

Judy McLeod is a member of the Genesee County Medical Society Auxiliary.



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REFINING THE ART OF INSURANCE

Dean Sienko, MD,

Working to preserve quality health care

"If you have the tools, you can do it"

By Patrick R. Wolski

"How many hours do you work?" "How much do you make?" "Can you fire people?" These are just a few of the questions asked of Dean Sienko, MD, a physician contributing his time in order to help students understand the reality of a medical career and the exciting and fascinating nature of medicine.

For the past year, Doctor Sienko has been attending middle and high school job fairs, career days, and health fairs as a representative of the medical profession. "I try to give young students a broad idea of just what it is that doctors do," he explains. Ideally, Doctor Sienko's goal is to develop a cooperative library of information, open to all doctors, that would enable other physicians to participate in similar programs for students.

As delegate to the MSMS Young Physician's Section, Doctor Sienko helped initiate this pilot program which encourages doctors to contribute their time and expertise toward helping students understand the many aspects of a medical career. By sharing experiences with students, Doctor Sienko hopes physicians will be able to capture the interest of potential future doctors, as well as teach students the various responsibilities and duties of being a physician.

"One of the keys to the medical profession," he comments, "is attracting good people that will keep the quality of our health care high."

Born and raised in a working class Milwaukee neighborhood, Doctor Sienko was the only member of his immediate family to attend college. Without the guidance of any kind of medical role model, he entered the University of Wisconsin at Milwaukee as a pre-med student.

"It was scary," he recalls. "I remember the horror stories of how you could never



get into medical school if you got a B." After successfully completing his undergraduate work, he did his graduate studies at University of Wisconsin at Madison. He interned at Cook County Hospital in Chicago, and completed his residency at the Centers for Disease Control in Atlanta, specializing in preventative medicine.

After several years of working for the federal government, Doctor Sienko came to Lansing. For nearly two years now, Doctor Sienko has served as medical director at the Ingham County Health Department. He also serves as medical examiner for Ingham County.

In addition to his duties as administrator and community physician, he also is a flight surgeon in the National Guard and is responsible for ensuring the health of pilots and crew members.

While on the ground, he works closely with the American Cancer Society and chairs a committee on breast cancer. Doctor Sienko is a member of the American Medical Association, as well as MSMS.

One organization he feels strongly about is Mothers Against Drunk Driving (MADD). "Michigan had over 800 drunk driving deaths last year alone, and these," he feels, "are preventable deaths." He hopes that his efforts with MADD will help educate people and reduce the death toll, and he shares the importance of not drinking and driving with the kids he speaks with. Additionally, he has done famine relief work in Africa, and has spent time in Central America working in the field of vaccination studies.

With so many commitments, it is hard to imagine where he finds the time to deliver presentations to school kids. But to

Doctor Sienko, as a public physician, helping students to realize their potential and perhaps choose a career in the medical field, is part of his job.

Doctor Sienko believes that the social image of physicians has changed over the years, and is due to a stigma that society places on the importance of choosing an occupation that puts you in a high income bracket. "We live in a quick fix society," he assesses, "and money is the quickest fix of all."

By sharing his experiences with prospective health care workers, he hopes to paint a realistic picture of the life of a physician, the sacrifices as well as the salaries, and to show students the benefits a medical career offers aside from the economic aspect of the job.

Beyond information on the medical profession, Doctor Sienko's presentations have another important function — to offer general safety messages. His position as community doctor gives Doctor Sienko a feeling of responsibility to the young people of Ingham County. Common themes include the dangers of smoking, general physical fitness, and vehicular safety. "If I go to a school and give a talk about medicine as a career and throw in some things about wearing seatbelts, then I'm doing my job, not just volunteering."

Doctor Sienko and members of the MSMS Young Physicians Section are using these presentations to try and improve low national science scores. An additional concern is that the pool of qualified candidates for medical school is shrinking. By contributing valuable time to these students, Doctor Sienko and others hope their efforts will help recruit the physicians of tomorrow.

Although a physician's time is valuable and critical to the program, Doctor Sienko said it is not all that is needed.

What he is proposing is a communal pool of materials, donated by doctors for doctors, that would be available to any physician asked to give a lecture. The value of these materials could be enormous. According to Doctor Sienko, physicians often feel that lecturing to students would be uncomfortable and difficult because they do not know what to say. Utilizing the collected materials, a doctor could avail himself/herself of interesting x-ray slides, schematic drawings, and other demonstrational aides. By presenting the information with such devices as these, doctors will be able to grab the attention of the

Continued on next page

kids and keep it.

Doctor Sienko realized early on that if he talked about the administrative aspects of his job or committees he heads, "they're going to be bored to tears!" His presentations now include the use of his National Guard flight suit, schematic videotapes of coronary angioplasty, and various other attention-getting devices. By including things out of the ordinary, he feels that the students better understand what he is saying and can visually comprehend the things he describes.

Although the project is just getting off the ground, Doctor Sienko is confident that other doctors have encountered the same situations and would welcome such a source of educational materials. He believes that if other physicians become interested in the program, the types of materials available will eventually become great enough that laser lights and other highly technical aides could be obtained from the pool.

"I want to have an array of things — different, interesting things," he says. "I want to grab their attention." By using such "props," Doctor Sienko hopes that he can better illustrate various points and help in the students' understanding of the practical application of medical and surgical techniques.

He also hopes that the fascinating nature of the materials will appeal to students who have thought about a career in medicine, as well as those who will simply gain a better idea of just what it is that doctors do.

Doctor Sienko hopes to help kids who are uncertain about their future. "It's a reward to me when I see students that look to a future in medicine," he says of his efforts. He shares with them the attitude that "If I can do it, so can you." ■

Patrick Wolski is an East Lansing-based freelance writer.

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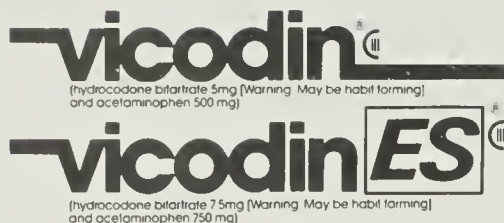
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1. Data on file, Knoll Pharmaceuticals

2. Standard Industry new prescription audit.

Please see adjacent page for brief summary of prescribing information.



INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS:

Allergic-Type Reactions: VICOIN/VICOIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICOIN/VICOIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICOIN/VICOIN ES Tablets are used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICOIN/VICOIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy:

Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICOIN/VICOIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

Labor and Delivery: Administration of VICOIN/VICOIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICOIN/VICOIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

Gastrointestinal System: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICOIN/VICOIN ES Tablets may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

DRUG ABUSE AND DEPENDENCE:

VICOIN/VICOIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICOIN/VICOIN ES Tablets should be prescribed and administered with caution.

OVERDOSEAGE:

Acetaminophen Signs and Symptoms: In acute acetaminophen overdose, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdose, apnea, circulatory collapse, cardiac arrest and death may occur.



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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

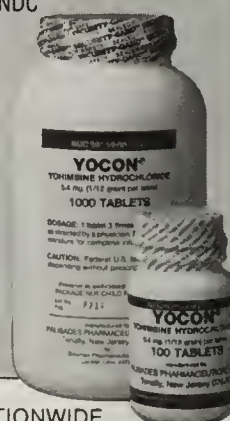
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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DEATHS

Charles E. Farber, MD *Grand Rapids*

Charles E. Farber, MD, a general practitioner, died May 11. He was 77. Doctor Farber was a member of the Kent County Medical Society since 1938. He received his medical degree from the University of Iowa in 1936. After serving in the military from 1941-45, he established his practice as a family practitioner in Grand Rapids. Doctor Farber was president of the Kent County Medical Society in 1968, a trustee of the Kent Medical Foundation, and was awarded in 1986 for 50 years of service.

Walter W. Hammond, MD *Plymouth Township*

Walter W. Hammond, MD, a general surgeon, died April 19. He was 86. A 1931 graduate of the University of Michigan Medical School, Doctor Hammond began his medical practice in Plymouth in 1938. He worked on the staff of Plymouth State Hospital, Sessions Hospital in Northville, Mt. Carmel Mercy Hospital in Detroit, Beyer Memorial Hospital in Ypsilanti, St. Joseph Mercy Hospital in Ann Arbor, and St. Mary Hospital in Livonia. Doctor Hammond was a longtime active physician in the community. He was a member of the Michigan State Medical Society.

Pedro G. Hoyos, MD *Grosse Pointe Shores*

Pedro G. Hoyos, MD, an anesthesiologist, died April 19. He was 63. Doctor Hoyos was a graduate of the University of Havana School of Medicine. He was an anesthesiologist at Cottage Hospital in Grosse Pointe Farms for 16 years. Doctor Hoyos was a member of the American Medical Association, the American Society of Anesthesiologists, the Cuban Medical Society in Exile and the Michigan State Medical Society.

Wilbur E. Johnson, MD *New Baltimore*

Wilbur E. Johnson, MD, a family physician, died April 11. He was 64. Doctor Johnson received his medical degree in 1954 from the University of Iowa. He practiced in East Detroit for 34 years. Doctor Johnson was on staff at St. John Hospital, Saratoga Hospital and Macomb Hospital Center. He was a member of the Michigan State Medical Society.

John P. Ottaway, MD *Detroit*

John P. Ottaway, MD, an obstetrician/gynecologist, died May 22. He was 83. Doctor Ottaway earned both his undergraduate and med-

ical degree from the University of Michigan. He was the former chief of the Department of Obstetrics and Gynecology at St. John Hospital, Detroit. Doctor Ottaway, who retired in 1978 after practicing medicine for over 47 years, organized the ob-gyn department at St. John Hospital when it opened in 1951. He was a member of the Michigan State Medical Society, and numerous local, national and international medical societies.

Dean B. Smith, MD *Grand Rapids*

Dean B. Smith, MD, a general practitioner and surgeon, died May 20. He was 70. Doctor Smith received his medical degree from the University of Illinois College of Medicine in 1951. He served on the staff of Blodgett Memorial Hospital for 35 years. For the past 14 years, Doctor Smith was a volunteer of the Christian Medical Society, performing surgery on the needy in the Dominican Republic. He was a member of the Kent County Medical Society and the Michigan State Medical Society.

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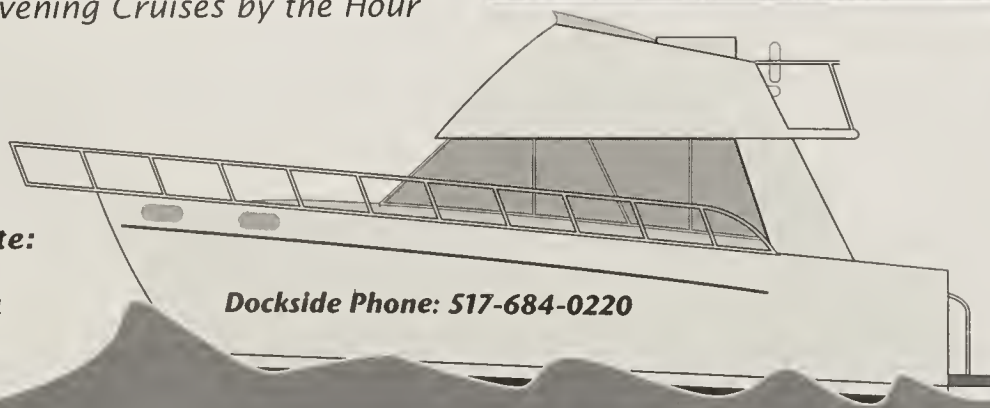
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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Angela E. Ambrosia, MD — FP
24555 Haig
Taylor 48180

Catherine M. Baase, MD — FP/OM
2605 Willard
Saginaw 48602

Gregory S. Brown, MD — NEP/PUD
4701 Towne Centre Rd. #202
Saginaw 48604

Mark D. Clark, MD — AN
502 Bronson Medical Center
Kalamazoo 49007

Robert H. Cleland, MD — GS
3401 Ludington St.
Escanaba 49829

Rolalind Cohen, MD — EM
26201 Drake
Farmington Hills 48331

Karen A. Cornell, MD — PD
1675 Leahy #405
Muskegon 49442

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19237 Van Dyke
Detroit 48234

Frederick M. DeTorres, MD — IM
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Melvindale 48122

Deborah L. Duncan, MD — FP
238 W. Caroline St.
Fenton 48430

Drore E. Eisen, MD — D
1312 Granger
Ann Arbor 48104

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4200 Fashion Sq. Blvd.
Saginaw 48603

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28295 Schoenherr
Warren 48093

Jonathan Fratkan, MD — PTH

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East Lansing 48824

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Livonia 48152

Benn B. Gilmore, MD — OTO
1993 Shorepointe
Grosse Pte. Woods 48236

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Taylor 48180

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Farmington 48024

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Monroe 48161

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Detroit 48202

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Marquette 49855

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Saline 48176

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Adrian 49221

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Sylvan Lake 48053

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St. Clair Shores 48082

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MEETINGS

MSMS Meetings

July

12-15, MSMS Board of Directors Meeting, Grand Traverse Village, Traverse City, MI. Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

August

6-10, MSMS/PSG, Conomikes Medical Office Management Institute, Grand Traverse Resort, Traverse City, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

September

14,15, MSMS/PSG, AMA's Starting Yourself in Medical Practice: Selecting an HMO or Private Practice, Hyatt Regency, Dearborn, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

18, MSMS Public Affairs/Leadership Conference, Radisson Hotel, Lansing, MI. Contact: Mary Anne Ford, Chief, State Government Affairs (517) 337-1351.

19, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

October

3, MSMS/PSG, Health Law Update, Hyatt Regency, Dearborn, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

3,4, MSMS/PSG, Third Party Reimbursement. 3rd - Hyatt Regency, Dearborn, MI. 4th - Amway Grand, Grand Rapids, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

9,10,11, MSMS/BCBS Medicare. 9th - Amway Grand, Grand Rapids, MI. 10th - To be announced, Bay City, MI. 11th - Weber Inn, Ann Arbor, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

17,18, MSMS/PSG, Retirement Planning. 17th - Hyatt Regency, Dearborn, MI. 18th - Amway Grand, Grand Rapids, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

23,24,25, MSMS/PSG, Advanced Coding. 23rd - Dearborn Inn, Dearborn, MI. 24th - To be announced, Lansing, MI. 25th - Bay Valley Inn, Bay City, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

31, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

AMA Meetings

October

11-12, Ninth Annual AMA Science Reporters Conference. Contact: John Hammarley, (312) 645-4417.

Michigan Specialty Society Meetings

July

20-22, Michigan Society of Medical Assistants, Summerfest-1990, Gaylord, MI. Contact: G. Warden-Day CMA, 4574 Jamm Rd, Pontiac, MI 48055. (313) 391-1204.

September

6,13,27, Michigan Psychoanalytic Institute Discussion Series for Parents: Toddlerhood. Contact: Michigan Psychoanalytic Institute, Extension Division. (313) 559-5855.

13, Michigan Psychoanalytic Society, Psychoanalysis and Psychotherapy: A Contemporary Perspective. Contact: John J. Hartman, Chairman (313) 559-5855 or (313) 557-8633.

October

11,18,25, Michigan Psychoanalytic Institute Discussion Series for Parents: Mid-Childhood. Contact: Michigan Psychoanalytic Institute, Extension Division. (313) 559-5855.

25, Michigan Psychoanalytic Society, Freud and Canard Ferdinand-Meyer. Contact: John J. Hartman, Chairman (313) 559-5855 or (313) 557-8633.

National Specialty Society Meetings

July

23-26, The American College of Physician Executives: Summer Executive Symposium, Montreal, Quebec, Canada. Contact: The American College of Physician Executives, (813) 287-2000.

27-30, American Academy of Sport Physi-

cians: Annual Meeting, Seattle, WA. Contact: Janie Zimmer, Academy Coordinator, 17113 Gledhill Street, Northridge, CA 91325. (818) 886-7891.

August

17-19, American Academy of Family Physicians: National Conference of Family Practice Residents and Students, Kansas City, MO. Contact: Beth Paulsen, Manager, (800) 274-2237, ext. 4420.

September

9-13, American Academy of Otolaryngology - Head and Neck Surgery: Annual Meeting, San Diego, CA. Contact: Pauletta Reid, Administrative Secretary, (312) 645-4412.

16-19, American College of Emergency Physicians: Annual Meeting, San Francisco, CA. Contact: Pauletta Reid, Administrative Secretary, (312) 645-4412.

21-23, Society of Thoracic Surgeons: Interim Meeting, Chicago, IL. Contact: Pauletta Reid, Administrative Secretary, (312) 645-4412.

21-26, American College of Radiology: Annual Meeting, Nashville, TN. Contact: Pauletta Reid, Administrative Secretary, (312) 645-4412.

October

5-10, American Academy of Pediatrics: Annual Scientific Meeting, Boston, MA. Contact: Pauletta Reid, Administrative Secretary, (312) 645-4412.

6-8, American Academy of Family Physicians: Congress of Delegates, Dallas, TX. Contact: Beth Paulsen, Manager, (800) 274-2237 ext. 4220.

7-11, American Academy of Family Physicians: Scientific Assembly, Dallas, TX. Contact: Beth Paulsen, Manager, (800) 274-2237 ext. 4220.

Other Meetings

August

18-24, The Ninth Annual Meeting of The Society of Magnetic Resonance in Medicine, Contact: SMRM, 1918 University Ave., Suite 3C, Berkeley, CA 94704. (415) 841-1899.

September

24-25, 5th Annual Urological Postgraduate Course. Contact: Ananias C. Diokno, MD, William Beaumont Hospital. (313) 288-2554.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

July

12-14, First Bristol-Myers Squibb Symposium on Pain. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 16 hours Category I Credit.

20-23, Sixteenth Annual Advances in the Management of Infectious Diseases. **Location:** Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 11 hours Category I Credit.

22-25, 4th Annual Symposium on Breast Disease. **Location:** Grand Traverse Resort, Traverse City, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Ted Ciganik, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 13 hours Category I Credit.

24-27, Cardiology Update. **Location:** Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 10 hours Category I Credit.

August

4-5, Diabetes & Endocrinology Update. **Location:** Grand Traverse Resort Village, Traverse City, Michigan. **Sponsor:** University of Michigan Medical School, Division of Endocrinology and Metabolism, Department of Internal Medicine. **Contact:** Registrar, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 8 hours Category I Credit.

17-18, Endoscopic Sinus Surgery. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology-Head and Neck Surgery. **Contact:** Teresa Mitchell, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 15 hours Category I Credit.

19-22, Internal Medicine Update. **Location:** Grand Hotel, Mackinac Island, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 11 hours Category I Credit.

October

1-2, Update on Pulmonary and Critical Care Medicine. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 14 hours Category I Credit.

18-20, 13th Annual Seminar in Diagnostic Ultrasound. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** The Registrar, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 14 hours Category I Credit.

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DIRECTOR NEW FAMILY MEDICINE RESIDENCY URBAN TRACK: BS/BE PRIMARY CARE PHYSICIAN needed to head an interdisciplinary team in new urban family medicine training track. Experience and interest in teaching in an urban setting essential. For more information contact: Martin Lipsky, MD., Mercy Family Practice Residency Program, 2127 Jefferson Ave., Toledo, Ohio 43624. (800) 222-8489.

FAMILY MEDICINE PHYSICIANS PRACTICE OPPORTUNITIES — SOUTHEASTERN MICHIGAN. Providence Hospital is seeking Board Eligible/Certified Family Physicians for practice opportunities in the Providence network of family health centers. These family health centers serve smaller congenial communities in the western suburbs of Metropolitan Detroit. Core groups of family physicians create an atmosphere conducive to the practice of family medicine. Access to tertiary care and family-centered obstetrical care available. All practice opportunities sponsored by Providence Hospital, Department of Family Practice. An excellent salary and benefit program awaits the selected individuals interested in true family medicine. Please forward a curriculum vitae in confidence to: Rob Stenberg, Sen-

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Eli Lilly	 6
G.D. Searle	 33,34
Kidder Peabody	 46
Knoll Pharm	 39,40
Lab of Clinical Medicine	 8
M-Labs	 13
M-Line	 BC
Max-C Charters	 41
Medical Search Group	 46
Metric Medical	 31
MPMLC	 IFC
Palisades Pharmaceutical	 40
Physician Service Group	 1
PICOM	 36
Profee	 30
Security Pacific	 26
Stratton-Cheeseman	 4
Stratton-Cheeseman Risk Management	 19,21
US Air Force	 29

PRESIDENT'S PAGE

MSMS *must* allocate time, money to public health, environmental issues

By Susan H. Adelman, MD



What should MSMS be doing about the environment? Leaving aside the obvious answer of decreasing the number of lawyers, bureaucrats and health care cost containment types now in our environment, what else do we want to do?

With all the resources and time MSMS routinely pours into the areas which we must monitor and impact upon, do we have the time and money to allocate to public health and environmental issues? Is this something we really have to do? I submit that the answer is: we must.

Today, much of the screening and vaccination of school children falls to public health clinics. When infant mortality rises in our cities, the public health department sets up task forces. When it finds out that poor women do not obtain sufficient prenatal care, the state tries to put together prenatal care programs. When fish in our lakes are contaminated with toxins, the public health department publishes information on which fish we should eat and how we should prepare them.

Meanwhile, where are the medical profession and our official organizations? If we do not participate in these areas, they will become generally accepted as within the purview of public health, not of medicine. To a large extent, this has already happened. Not only do we have public

health clinics hiring physicians to take care of their patients, but they also design all the policies and set up the programs to deliver this care.

By the same token, if we do not want to make house calls, we may be perfectly content to see nurses take over home health care, which is becoming a big business.

Perhaps my point is still not clear. We hear a great deal about an impending oversupply of physicians, which may not actually occur, according to the latest information. Think about what will happen to the ratio of physicians to patients if physicians relinquish home health care to nurses, chemical dependency care to substance abuse counselors and social workers, care of low income patients to public clinics, and the health of the environment to our public health departments.

Do we even have an adequate number of physicians who are knowledgeable about toxins in water, air and the food chain? What do we tell our patients in our offices about these matters, when we provide our primary care preventative health services? Can we tell our patients about the potential effects of atmospheric pollutants on their respiratory conditions? The Pennsylvania State Medical Society Commission's on Public Health and Toxic Substances has prepared an exhaustive treatise on the effects of pollutants on respiratory illness: *The Human Health Effects of Air Pollutants and Acid Rain*. This should serve as a prototype of what a medical society could do.

Who does the state go to for information on toxic substances or safe coliform levels in well water? They do not come first to physicians.

Who researches the effects of unclean air on our lungs and disseminates this information to the public? Is it us, or is it the Department of Public Health? Who goes out into the community to be sure that children are vaccinated? That is a traditional example of a public health service. Who keeps abreast of environmental

threats to health, of the potential public impact of new strains of viruses, or of the possible interactions of environmental and infectious factors on the occurrence and spread of epidemics? Who within our profession even has the expertise to put this material together? That is my first practical question to you.

Would all those who have expertise in any of these areas which overlap with public health please contact us at MSMS, so that we know you are out there? Would all those who are knowledgeable about toxicology and are able to provide expertise in matters of clean air and water please let us know who you are? Would those of you who have this expertise please tell us what you think our priorities should be? We need to know where you think we should put our energies and resources, so we can have maximum impact.

We physicians must not allow ourselves to continue becoming increasingly more expert on an increasingly narrow body of knowledge. Let us not focus increasing amounts of our professional and organizational attention on fewer issues. When we do so, we relegate all other areas of medicine to nonphysicians, which diminishes our profession forever.

In setting organizational priorities, pocketbook issues usually have such immediacy that MSMS is under pressure to tend to them first. We then risk having no time or resources left over for the next set of priorities. Many of these next priorities are what our patients recognize most clearly as promoting their interests.

If we concentrate on pocketbook issues, we may expect scant support from our patients. If we concentrate on what they see as *their* interests, they may even be moved to support some of *our* issues. This is what is called a win-win situation. ■

Doctor Adelman is MSMS president.

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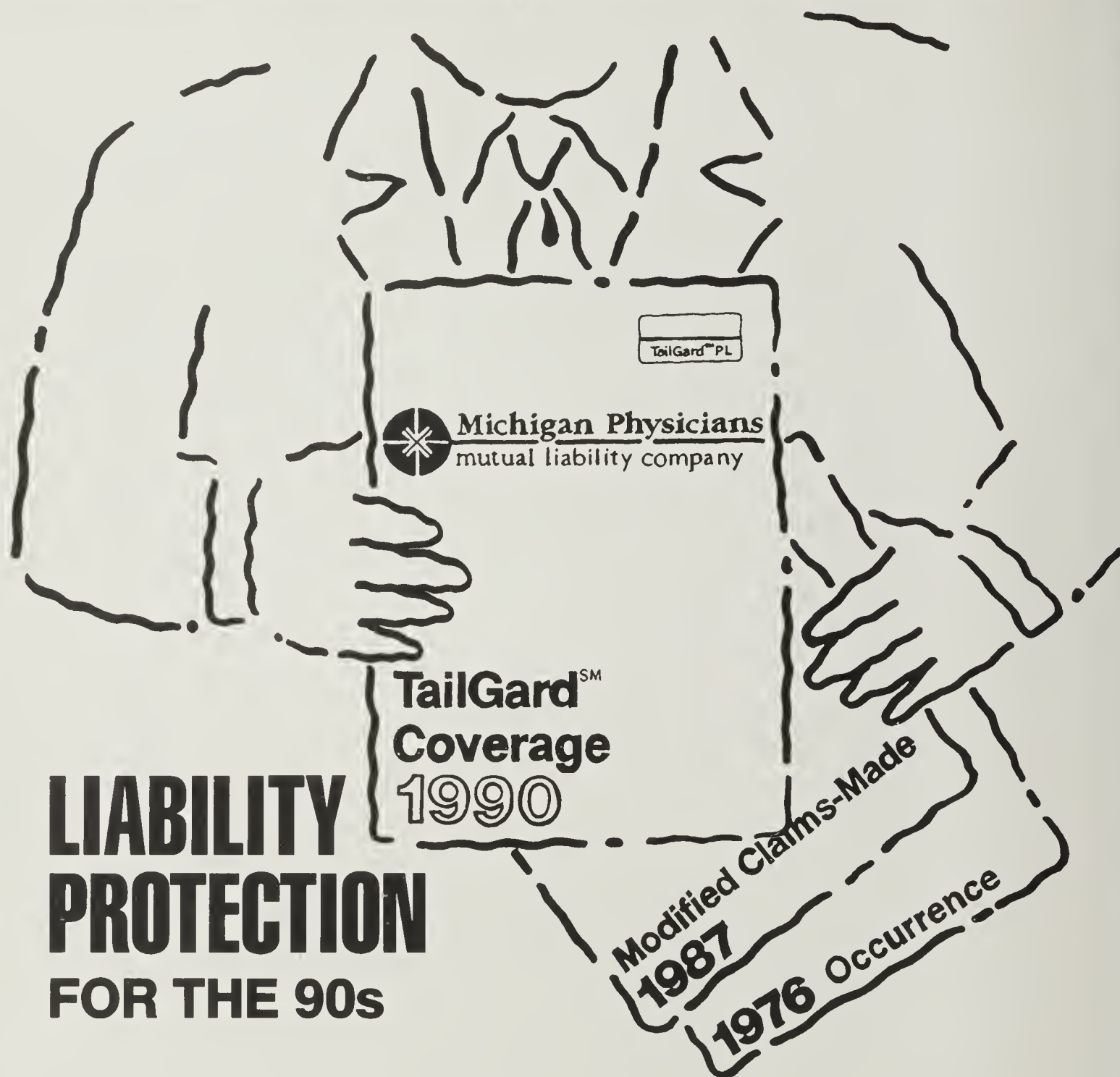
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DIGEST OF PROCEEDINGS

All of the proceedings of the 1990 MSMS House of Delegates meeting, plus a variety of photo highlights, are featured in this month's issue of *Michigan Medicine*. This issue serves as the official digest of proceedings. We hope you find its presentation interesting and informative. For your convenient use, please note the following arrangements of contents: Each report is followed immediately by the action of the reference committee on that report and then by the House Action on the report of the reference committee. Only resolved portions of the Resolutions appear as they were finally approved or disapproved by the House.

TABLE OF CONTENTS

CALL TO ORDER AND SPECIAL REPORT

Call to order	7
Invocation	7
Report of the Committee on Credentials and Tellers	7
Report of the Committee on Rules and Order of Business	7
Speaker's Remarks	8
Report of the AMA Delegation	27
Report of the Michigan State Medical Society Auxiliary	27
Report of the Peer Review Of Michigan (PROM)	28
Report of the Physician Service Group, Inc.	28
Report of the Health Education Foundation	28
Report of the MSMS Group Insurance Trust	28
Address of the President	30
Address of the President-Elect	33

PRESENTATIONS OF THE BOARD

Remarks of the Board Chairman	38
Report of Board Activities	40

REPORTS OF HOUSE OF DELEGATES COMMITTEES

Committee on Constitution and Bylaws	54
Committee on Ways and Means	54

RESOLUTIONS

House action on resolutions	57
See page 6 for titles of resolutions.	

SPECIAL MEMBERSHIPS

Life Memberships	68
Retired Memberships	68

AWARDS

Plessner Award	68
Fifty-Year Awards	68
Flag Award	69
National President's Award	69
Presidential Citations	69
AMA House of Delegates Certificates of Appreciation	69

ELECTIONS

REFERENCE COMMITTEE PERSONNEL	70
RECORD OF DELEGATES' ATTENDANCE	71

DEPARTMENTS

Meetings	74
Category I Courses	77
Classifieds	81
Advertising Index	83
President's Page	84

"Mini-residency program needed."

BY SUSAN H. ADELMAN, MD



Page 7



Page 34



Page 58

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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Resolution	Page
1-90A Radioactive Waste Disposal	57
2-90A In Opposition to the Low-Level Radioactive Waste Policy Act of 1980	57
3-90A Third Party Imbursement for Physician Services	57
4-90A Optional Health Insurance Coverage for MSMS Members	57
5-90A Reimbursement for Medical Trauma Care Related to Drug Enforcement	57
6-90A Medical Mediation Panels	57
7-90A National Practitioner Data Bank Implementation	57
8-90A Nursing Home Admission Assessment	57
9-90A Indemnification for Indigent Obstetrical Care	57
10-90A Liability Insurance Premium Renewal Notices	57
11-90A BCBSM Cease Implementation of the Physician Retrospective Profiling Programming	57
12-90A MDCPAC Board to Include Graduates of Foreign Medical Schools	57
13-90A Cataract Survey Pre-Certification	58
14-90A Automobile No-Fault Insurance	58
15-90A Managed Care Periodic Interim Payment Programs	58
16-90A Closing of Small Community Hospitals	58
17-90A Ophthalmology for the Lower Income Patient	58
18-90A Physician Testimony is the Practice of Medicine	58
19-90A Adoption	58
20-90A Universal Payment Program for Birth Procedures	58
21-90A Graduates of Foreign Medical Schools Members to International Medical Scholar Program	58
22-90A Medicare Reimbursement	58
23-90A Clean Air Inside Airplanes	58
24-90A Family Planning as a Basic Health Service	58
25-90A Interstate Reimbursement Parity for Obstetrical Services	58
26-90A Michigan as Initial Participant in AMA National Credentials Verification Service	58
27-90A Conflicting Standards Between Specialty Societies and Michigan Department of Public Health	59
28-90A Establishment of Tighter Communications Between Prosecutorial and Licensing Agencies and Organized Medicine	59
29-90A Managing Stress as a Physician	59
30-90A Alternative Methods of Medical Practice	59
31-90A Systems for Dictated Medical Records in Emergency Departments	59
32-90A Good Samaritan Law Extended to Indigent Care	59
33-90A Clinical Laboratory Improvement Act of 1988	59
34-90A Physician Professional Responsibility	59
35-90A Cardiopulmonary Resuscitation (CPR)	59
36-90A On-Site Automatic Cardiac Defibrillators and Trained Personnel in Sports Arenas	59
37-90A Name Change from Graduates of Foreign Medical Schools to International Medical Graduates	59
38-90A Call Me Physician	59
39-90A Promotion of Energy Efficiency to Reduce Pollution	60
40-90A Physician Recruitment in Michigan	60
41-90A Interest on Medical Education Tax Deductible	60
42-90A MSMS Medical Liability Media Campaign	60
43-90A Treatment of Chemical Dependency	60
44-90A Child Care for Mildly Ill Children	60
45-90A Study the Feasibility of State Medical Societies Processing Medical Licensure	60
46-90A Peer Review Organization of Michigan (PROM) Anonymity	60
47-90A Environmental Health Care Committee	60
48-90A National Competency Exams for Emigres Having Professional Health Care Education and Training to Expediate the Obtainment of Visas and Employment	60
49-90A Access to Medical Care for the Poor	60
50-90A Medicaid Obstetric and Pediatric Services: Michigan's Noncompliance with Federal Regulations	60
51-90A Term of Office for AMA Positions	61
52-90A Delay in Health Care Facility and Technology Development	61
53-90A National Practitioner Data Bank	61
54-90A A New BCBSM Contract	61
55-90A Expiration Dates on Medications	61
56-90A BCBSM Pre-Admission Approvals	61
57-90A Development of a List of Physician Volunteers	61
58-90A Fair Fees for Chart Copying	61
59-90A Physician's Pharmacy Licensing Fee	61
60-90A Recycling and Using Recycled Paper	61
61-90A Automobile No-Fault	61
62-90A Health Insurance Consultation Service	61
63-90A Recertification of State License	61
64-90A Resident Hours	61
65-90A Family Planning	62
66-90A Opposition to Specialty Recertification Tied to State Licensure	62
67-90A Care for Underserved Areas	62
68-90A Family Planning	62
69-90A Update Treatment for Substance Abuse	62
70-90A IRS Reclassification of CME Costs	62
71-90A Medicaid Reimbursement	62
72-90A Opposition to Malpractice Information in the National Practitioner Data Bank	62
73-90A National Practitioner Data Bank	62
74-90A Certificate of Need Regulation	62
75-90A The Need for Adequate Time to Review the First Revision in Forty Years of the BSBSM Provider Contract	62
76-90A Clinical Care Guidelines	62
77-90A Oppose Omnibus Budget Reconciliation Act (OBRA 1989) Ruling	62
78-90A Unclaimed Bodies as Potential Tissue and Organ Donors	62
79-90A Discontinue Unnecessary Time Records for the Michigan Society of Pathologists	62
80-90A Duplicate Bureaucratic Regulations	62
81-90A Excessive Medical Administrative Costs	62
82-90A National Practitioner Data Bank	62
83-90A Modifications in the Arbitration Law	63
84-90A Litigation of Non-Meritorious Suits	63
85-90A Insurance Premiums	63
86-90A Adjustment of Jury Verdicts for Patients Contributory Negligence	63
87-90A Cost of Medical Waste Disposal	63
88-90A Medicaid Denial Review	63
89-90A Shortage of Nursing Home Beds	63
90-90A Directory of Graduate Medical Education Programs	63
91-90A Immunization and Preventative Health Care for Children	63
92-90A Endorsement of a Living Will	63
93-90A Initiative to Clarify State and Federal Regulations Which Affect Michigan Physicians	63
94-90A Forward Planning for Medicine	63
95-90A Needs of Dementia Patients in Michigan	64
96-90A Graduates of Foreign Medical Schools Participation in Organized Medicine	64
97-90A Filling of Available Residency Spots	64
98-90A Foreign Medical Graduate Examination in Medical Sciences (FMGEMS) Scores Not Sole Criteria for Residency Selection	64
99-90A Graduates of Foreign Medical Schools Representation on Residency Selection Committees	64
100-90A Inclusion of Residency Interview Costs in the Financial Aid of Fourth Year Students	64
101-90A Sharing the Financial Manpower Burden of the Human Genome Project with Other Nations	64
102-90A Medical School Financial Aid Reforms	64
103-90A Graduates of Foreign Medical Schools Section Representation for Resident Physicians	64
104-90A MSMS Involvement in Workers' Compensation	64
105-90A Graduates of Foreign Medical Schools Section Representation for Non-Hospital Affiliated Physicians	65
106-90A MSMS Increased Involvement in Workman's Compensation Fee Schedules	65
107-90A Eliminate Worker's Compensation Medical Fee Schedule	65
108-90A Eliminate the Use of Government Mandated Medical Fee Schedules	65
109-90A Legislation re BCBSM Health Insurance Programs	65
110-90A Legislation to Guarantee that BCBSM Gives Physicians Due Process	65
111-90A Audit of BCBSM	65
112-90A Commercial Advertising by Trial Attorneys that Heightens the Liability Crisis in Michigan	65
113-90A Encourage Showing of the Auxiliary Medical Liability Videotape	65
114-90A Support of Charles C. Vincent, MD	65
115-90A Surgical Assistants	65

Michigan State Medical Society
House of Delegates
125th Annual Session
May 4-6, 1990



Delegates considered 115 resolutions at the 1990 MSMS House of Delegates meeting May 4-6 in Grand Rapids. Topics ranged from radioactive waste disposal to medical school financial aid reforms.

Call to Order

The 125th Annual Session of the House of Delegates of the Michigan State Medical Society, convened at 7:30 p.m., at the Amway Grand Plaza, Grand Rapids, Speaker Robert D. Burton, MD, and Vice-Speaker Robert D. Allaben, MD, presiding.

Invocation

The Speaker called upon John C. Rienstra, MD, to give the invocation.

Report of the Committee on Credentials and Tellers

Chairman Duane E. Smith, MD, reported a quorum seated, the majority of whom were not from any one county.

Report of the Committee on Rules and Order of Business

Chairman Reed K. Freidinger, MD, reported the actions of the Committee on Rules and Order of Business as follows:

Order of Business: The Committee on Rules and Order of Business approved the Order of Business for the 1990 Annual Session as printed in the Delegates' Handbook.

Late Resolutions: Nine late resolutions were presented to the Committee.

Resolution 107-90A "Eliminate Worker's Compensation Medical Fee Schedule" submitted by Robert A. Holmes, MD, and Omero Iung, MD, Ingham County, for Floyd G. Goodman, MD.

Committee Recommendation: That this resolution not be accepted for introduction.

Resolution 108-90A "Eliminate the Use of Government Mandated Medical Fee Schedules" submitted by Robert A. Holmes, MD, and Omero Iung, MD, Ingham County, for Floyd G. Goodman, MD.

Committee Recommendation: That this resolution not be accepted for introduction.

Resolution 109-90A "Legislation re BCBSM Health Insurance Programs" submitted by Robert A. Holmes, MD, and Omero Iung, MD, Ingham County, for Floyd G. Goodman, MD.

Committee Recommendation: That this resolution not be accepted for introduction.

Resolution 110-90A "Legislation to Guarantee that BCBSM Gives Physicians Due Process" submitted by Robert A. Holmes, MD, and Omero Iung, MD, Ingham County, for Floyd G. Goodman, MD.

Committee Recommendation: That this resolution not be accepted for introduction.

Resolution 111-90A "Audit of BCBSM" submitted by Robert A. Holmes, MD, and Omero Iung, MD, Ingham County, for Floyd G. Goodman, MD.

Committee Recommendation: That this resolution not be accepted for introduction.

Resolution 112-90A "Commercial Advertising by Trial Attorneys that Heightens the Liability Crisis in Michigan" submitted by Robert A. Holmes, MD, and Omero Iung, MD, Ingham County, for Floyd G. Goodman, MD.

Committee Recommendation: That this resolution not be accepted for introduction.

Resolution 113-90A "Encourage Showing of the Auxiliary Medical Liability Videotape" submitted by Robert C. Packer, MD, Muskegon County.

Committee Recommendation: That this resolution be accepted.

Resolution 114-90A "Support of Charles C. Vincent, MD" submitted by Robert S. Levine, MD, Oakland County.

Committee Recommendation: That this resolution be accepted.

Resolution 115-90A "Surgical Assistants" submitted by Jaime V. Aragon, MD, Oakland County.

Committee Recommendation: That this resolution be accepted.

Speakers' Report

Robert D. Burton, MD, Speaker

Robert D. Allaben, MD, Vice Speaker

Here is a brief review of the progress in implementing the resolutions adopted at the 1989 Annual Session of the House of Delegates.

The House took no action on Resolutions 2-89A, 9-89A, 16-89A, 19-89A, 26-89A, 46-89A, 58-89A, 62-89A, 70-89A, 78-89A, 79-89A, 83-89A and 131-89A. Resolutions 22-89A, 24-89A, 33-89A, 53-89A, 59-89A, 73-89A, 77-89A, 82-89A, 96-89A, 109-89A, 118-89A, 137-89A, 140-89A and 147-89A were disapproved.

Resolutions:

1-89A **Title: Use of Tobacco Recorded on Death Certificate.** Adopted as Amended.

This resolution directed MSMS to explore strategies for monitoring tobacco use as a cause of death through the Michigan death certificate.

Legislation has been introduced in both the House and the Senate to require death certificates to indicate if tobacco use was a factor contributing to death. No action is anticipated on the legislation, because the Michigan Department of Public Health has raised concerns that reports obtained through death certificates may not be accurate. The AMA considered a similar proposal, and opted to monitor laws in the states of Oregon and Washington to determine whether those states obtain accurate reports of tobacco use.

MSMS will continue to collect information about the success of death certificate reporting of tobacco use, and will monitor the progress of the AMA's activities in this area to share with the Michigan Department of Public Health in future activity on this issue.

2-89A **Title: Michigan Department of Public Health Reportable Diseases.** No Action.

3-89A **Title: Impact of Claims-Made Insurance on Young Physicians.** Adopted as Amended.

This resolution asked that MSMS work with malpractice insurance carriers to develop materials that educate physicians regarding claims-made coverage and occurrence coverage and that MSMS work to assure the availability of occurrence coverage in Michigan.

The MSMS Task Force on Professional Liability, Michigan Physicians Mutual Liability Company (MPMLC) and Physicians Insurance Company of Michigan (PICOM) developed educational materials on occurrence coverage and claims-made coverage. Both MPMLC and PICOM are sending these materials to their insureds and the medical community on a regular basis. In addition, the Task Force has urged both companies to continue offering occurrence coverage.

4-89A **Title: Support of Cholesterol Screening Program.** Adopted.

This resolution urged MSMS support for the AMA cholesterol screening program and expanded efforts for physician education in the area of nutrition and work with outside organizations involved in nutritional instruction.

The Board of Directors officially supported the AMA cholesterol screening program on January 17, 1989, when it adopted a recommendation of the Advisory Committee on Communications and Professional Relations. Component medical societies and member physicians were

urged to become involved through the summary of Board activities and *Medigram*. Local participation in the AMA program is handled by Doctor Art Ulene's "Feeling Good America" organization in California. The Planning Committee for MSMS Annual Scientific Meeting should be encouraged to offer more physician education about cholesterol because 1987 was the last time a course was offered. That course, "Patients with Lipid Disorders: A Practical Approach," was presented by Ford Motor Company Employee Health Programs.

5-89A

Title: Long-Term Care Insurance. Adopted as Amended.

This resolution asked that MSMS support the availability of long-term care insurance for Michigan residents and also that the Michigan Insurance Commissioner adequately inform the public on the availability of long-term care insurance and the coverage it provides.

This was referred to the MSMS Committee on Aging which determined that previous publications of the Michigan Insurance Commission addressing this subject are in existence. The Committee has recommended that the MSMS Board of Directors request the Michigan Insurance Commissioner to revise these documents to reflect the current long-term care insurance availability in Michigan.

The MSMS Advisory Committee on Health Care Policy is reviewing informational materials currently available through the Insurance Bureau, and will work with the MSMS Committee on Aging to offer suggestions for the further development and distribution of appropriate materials. Of particular concern is that information be provided to caution consumers that long-term care coverage is not necessarily part of private insurance policies.

6-89A

Title: Law Review for Michigan Physicians. Referred to the Board.

This resolution asked MSMS to develop and distribute educational materials concerning physician ownership of health care services and facilities.

The Committee on Medical Licensure and Discipline has been advised by legal counsel that, at this time, it would not be appropriate to develop educational materials to explain the state law that governs physician ownership of health care services and facilities because how the law will be interpreted by the courts is not yet clear.

7-89A

Title: Health Insurance Options for MSMS Members. Substitute Resolution (in lieu of 7-89A, 27-89A and 72-89A). Adopted.

Resolution 7-89A states the MSMS Group Insurance Trust review the member health insurance coverage in respect to its cost and benefits.

The Trustees of the Group Insurance Trust have been actively involved in negotiating with Blue Cross Blue Shield for the member coverage. Several major changes have been made in the benefit design resulting in reduced premiums for the majority of members. An additional optional benefit was added to the member coverages to include prescription drugs. The Trustees have commissioned an outside consultant to review its options in regards to the members health insurance. Additionally, the Trustees have conducted a member survey to determine the type of coverage members wanted.

It has been determined physicians residing in other states can continue to have Blue Cross Blue Shield coverage. However, national Blue Cross rules require residents of a state use the plan or plans in that state. This is due to the fact premiums collected must be sufficient to cover the health care in that particular location.

8-89A

Title: Physician Licensing Requirements. Adopted as Amended.

This resolution directed MSMS to work in cooperation with the Michigan Department of Licensing and Regulation and the Michigan Board of Medicine to expedite the processing of physician licensure and re-licensure applications and to develop educational materials outlining the specific requirements for licensure and re-licensure for distribution to MSMS members and perspective members.

MSMS is working with the Department of Licensing and Regulation to expedite the processing of physician licensure and re-licensure applications and to develop educational materials outlining the specific re-

	quirements for licensure and re-licensure. The House Special Ad Hoc Committee on Physician Licensure has recommended separating the functions of licensing and discipline. This separation should result in more timely processing of physician licensure and re-licensure applications.			care to the uninsured may have their liability expenses covered by a state fund.
4-89A	Title: Medically Necessary Guidelines. No Action.			MSMS was also successful in having liability issues addressed in the report of the Governor's Task Force on Access to Health Care, which will recommend use of the Fleming Report on Alternatives to Tort in developing means of addressing liability concerns as they relate to health services for the poor.
10-89A	Title: Worker's Compensation Health Care Services Fee Schedule. Adopted as Amended.	14-89A	Title: Health Professionals Recruitment Strategy. Amended and Referred to the Board.	The resolution called for MSMS support of legislative proposals to establish a health professional recruitment strategy in Michigan, to address health care needs in underserved areas of the state.
	This resolution directed MSMS to seek a delay in implementation of the workers compensation rules and to pursue all available means of revising the rules and the maximum allowable fee schedule.			The MSMS Board of Directors reviewed and endorsed SB 393, which establishes a recruitment strategy similar to the national health services corps. The legislation provides for a medical school loan repayment program for physicians who establish practice in underserved areas of the state. Underserved areas will include urban and rural areas where physicians are not available to address pressing health care concerns of the community, such as infant mortality. The legislation has been signed into law, and the Michigan Department of Public Health is now working with MSMS and other interested groups on implementation steps. The next step will be to secure funding to begin the program in the amount of \$1 million, through the Public Health Appropriations process.
	MSMS has, by letter to the Director of the Office of Health and Medical Affairs, requested a delay in implementation of the rules. Although our request was denied, legal action delayed implementation of the rules for several months.			
	Working closely with the MSMS Committee of Specialty Society Presidents, MSMS is now identifying specific problems with the rules and fee schedule, in order to develop recommendations for their revision. These recommendations will be considered by an Advisory Committee to the Office of Health and Medical Affairs, on which MSMS members David Jacknow, MD, and Lawrence Morawa, MD, serve. State officials have been made aware of the difficulties physicians have with the rules and fee schedule, and are committed to pursuing some changes through the Advisory Committee. The Advisory Committee plans to submit initial recommendations for revision of the rules to the Legislature's Joint Committee on Administrative Rules this fall. If approved, these revisions would become effective early in 1991. Revision of the rules is expected to be an ongoing process.	15-89A	Title: Drunk Driving in Michigan: A Time to Act. Adopted.	This resolution requested that MSMS support a number of measures to combat drunk driving, including establishment of a blood alcohol concentration of .05% as per se illegal for driving in Michigan.
11-89A	Title: Young Physicians Committee Participation. Withdrawn 4/17/89.			MSMS is working with the Michigan Secretary of State and the Michigan Coalition for Safety Belt Use in support of pending state legislation that would strengthen Michigan's drunk driving laws.
12-89A	Title: Adolescent Health Services. Substitute Resolution (in lieu of 12-89A, 85- 89A and 126-89A). Adopted.	16-89A	Title: BCBSM Audit Procedures. No Action.	
	This resolution supported the development of publicly funded projects to address health needs of adolescents, directs MSMS to initiate legislation permitting the dispensing of contraceptives through school-based health programs and calls for MSMS to pursue strategies to increase physician awareness of the special health needs of adolescents.	17-89A	Title: Third Party Cost Containment Programs. Adopted as Amended.	This resolution called for investigation of the impact of cost containment programs on the public health and the sharing of information on the effects of cost containment programs with appropriate public officials.
	As work begins on the Michigan Department of Public Health budget for the next fiscal year, MSMS will aggressively support continued funding for successful adolescent health programs, such as the Corner Clinic in Ypsilanti, and funding for new projects. The prohibition against dispensing contraceptives is an annual issue in budget deliberations, and MSMS will again support removing the existing link between state funding for school health programs and dispensing contraceptives.			The Advisory Committee on Health Care Policy has begun a review of literature pertaining to cost containment programs, and has found little information to support a correlation between cost containment programs and changes in health status. There is evidence, primarily anecdotal, to suggest cost containment programs have negative impact on the public perception of the health care they receive. The Committee will continue to explore this issue, and will share its findings with state officials and with the MSMS Advisory Committee on Communications and Professional Relations, for possible use as part of the C*A*R*I*N*G campaign.
	In 1989, a <i>Michigan Medicine</i> special report addressed health care concerns of adolescents; an upcoming issue on AIDS will include a feature on AIDS, sexually transmitted diseases and adolescents. The AMA has made adolescent health care needs a priority and MSMS will continue to promote AMA conference and resources to members.	18-89A	Title: Incorporation of Organ Donation Declarations into Health Insurance Data Banks and onto Insurance Cards. Adopted.	This resolution called for MSMS to pursue with the Insurance Commissioner the incorporation of organ and tissue donations declarations by health insurance policy holders and other insureds in health insurance data banks and on health insurance cards.
13-89A	Title: Health Services for the Poor. Adopted as Amended.			Initial discussions with the Insurance Commissioner on this issue have taken place. MSMS is currently pursuing this initiative with the MSMS-/Michigan Hospital Association Liaison Committee and the Interprofessional Committee with the State Bar of Michigan, as a follow up to the organ donor public relations campaign that was developed by the Michigan Hospital Association, Michigan State Medical Society and the State Bar of Michigan.
	The resolution called upon MSMS to develop resources for physicians establishing local projects to address health care needs of the poor. The resolution further requests exploration of alternatives for addressing the unique medical liability concerns of providing uncompensated or minimally compensated care.	19-89A	Title: Expand Imbursement Data. No Action.	
	MSMS has established a new Task Force on Health Care for the Uninsured, which will survey local medical societies to determine the scope of volunteer activities with which physicians are currently involved. The Task Force plans to use information about existing projects to develop information for physicians interested in pursuing similar efforts in their own communities. A number of liability issues are currently under study by the Task Force on Health Care for the Uninsured, the Medicaid Liaison Committee and the Task Force on Professional Liability, including the State Legal Expense Fund currently operating in Missouri. Under the Missouri law, physicians contracting with a state agency to provide	20-89A	Title: Establish Expert Witness Panels. Adopted as Amended.	This resolution asked that MSMS work with the specialty societies to

establish panels for each specialty to be available as expert witnesses in malpractice cases.

This resolution is being studied by the Committee of Specialty Society Presidents.

- 21-89A **Title: Shift Liability to Other Parties for Indigent Care.** Adopted as Amended.

This is one of several resolutions related to liability and health care for the poor, and called for MSMS to pursue the possibility of the state assuming responsibility for liability connected with care of Medicaid patients.

The Medicaid Liaison Committee is working with Department of Social Services officials on development of a State Legal Expense Fund, similar to that currently operating in Missouri. The fund extends governmental liability coverage to health care providers rendering uncompensated or minimally compensated care to patients, when they are operating under contract with the state. The Department of Social Services is currently seeking legal advice on Michigan law which might affect such a plan for Michigan. Following completion of that review, the Medicaid Liaison Committee will continue its study of the fund and its potential for Michigan.

- 22-89A **Title: Create a Fund for Suits Against Attorneys.** Disapproved.

- 23-89A **Title: Encourage Professional Liability Carriers and Doctors to Fight All Non-meritorious Suits.** Adopted as Amended.

This resolution asked that MSMS (1) encourage professional liability carriers to fight all non-meritorious suits to conclusion and (2) encourage all doctors to fight all non-meritorious suits to conclusion.

The MSMS Task Force on Professional Liability has been advised by both Michigan Physicians Mutual Liability Company (MPMLC) and Physicians Insurance Company of Michigan (PICOM) that it is the policy of both companies to fight non-meritorious suits. The Task Force reported on this development in the January 30 *Medigram* and urged physicians to fight non-meritorious suits to the end.

- 24-89A **Title: Increase Physician Representation on BCBSM Board.** Disapproved.

- 25-89A **Title: Increase Visibility of MSMS/BCBSM Liaison Activity.** Adopted as Amended.

This resolution asked MSMS's BCBSM Liaison Committee to increase their efforts in providing information on its activities to resolve physician concerns regarding BCBSM.

Various issues of *Medigram* have included the activities of the MSMS/BCBSM Liaison Committee. These activities have surfaced in the following issues: May 23, 1989; May 30, 1989; September 5, 1989; September 19, 1989; September 26, 1989; October 3, 1989; November 28, 1989.

Furthermore, we had an article printed in *Michigan Medicine* in November 1989 by Doctor Adelman and a special article will be placed in *Michigan Medicine* in January 1990 by MSMS staff regarding BCBSM activities with MSMS.

In addition, nine statewide BCBSM contract focus groups meetings took place around the state from January 1990 to March 1990. These meetings were developed by MSMS to gain local physician input for BCBSM to use in the development of their new provider contract.

- 26-89A **Title: Adequate Funding of Graduate Medical Education.** No Action.

- 27-89A **Title: Health Insurance Options for MSMS Members.** Substitute Resolution (in lieu of 7-89A, 27-89A, and 72-89A). Adopted. See Resolution 7-89A.

- 28-89A **Title: Pursuit of Mandatory State and County Membership.** Referred to the Board for study.

This resolution requested that MSMS continue aggressive pursuit of mandatory county and MSMS membership for attainment of licensure in Michigan.

The Committee on Medical Licensure and Discipline reviewed this res-

olution and has developed a report for the 1990 House of Delegates meeting. The report concluded that since it is not politically feasible, at this time, to have the state licensing and disciplinary authority transferred to MSMS, this resolution will be impossible to obtain.

- 29-89A **Title: Support of Legislation to Prohibit Vending Machine Sales of Tobacco Products.** Adopted as Amended.

This resolution asked that MSMS support efforts to enact legislation to prohibit vending machine sales of tobacco products and candy tobacco-facsimile products.

During the 1988-89 legislative session, MSMS was actively involved and successful in gaining passage of the "Michigan Health Initiative Program." This legislation, sponsored by Senator William Sederburg, provides for an increase in taxes on tobacco products for health promotion activities. During the legislative hearings on the Michigan Health Initiative Program, MSMS advocated the need to prohibit the sale of tobacco products through vending machines.

- 30-89A **Title: Expansion of the Good Samaritan Law.** Adopted as Amended.

This resolution asked that MSMS support Senate Bill 323, introduced by Senator Joe Schwarz, that would expand the Good Samaritan Law in Michigan to cover physicians who treat patients on an emergency basis in Michigan hospitals.

MSMS is working with the Michigan Hospital Association and Michigan Chapter of the American College of Emergency Physicians for passage of this legislation. SB 323 is currently before the Senate Judiciary Committee. A hearing on SB 323 is scheduled on May 3, 1990.

- 31-89A **Title: Medical Control of Prehospital Care Providers.** Adopted.

The resolution asked that MSMS support efforts to develop rules and regulations giving Emergency Medical Services Medical Directors the authority to specify requirements for their designated medical control areas.

House Bill 4952 was introduced this year to enable EMS Medical Directors to specify protocols, procedures, policies and staffing requirements which exceed the minimum standards established by the Michigan Department of Public Health. The legislation is the result of efforts by the Michigan EMS Coalition, and is currently under consideration by the Senate Health Policy Committee.

- 32-89A **Title: HMO "Hold Harmless" Clauses.** Referred to the Board for study.

This resolution asked that MSMS oppose state or federal laws that would allow HMOs to have "hold harmless" clauses which would abrogate them of responsibilities to both patients and providers in case of insolvency. The resolution also requested that MSMS encourage the enactment of legislation in Michigan that would require HMOs to develop a "guaranteed fund" to pay providers the claims rendered for patient care before HMO insolvency has been declared.

MSMS is working with Senator Joe Schwarz to develop legislation that will address the issues and problems related to HMO's in Michigan. MSMS anticipates this legislation to be introduced in the fall session of 1990.

- 33-89A **Title: Unify Osteopathic and Allopathic Medicine.** Disapproved.

- 34-89A **Title: Guidelines for Third Party and Free Standing Review Organizations.** Referred to the Board.

This resolution asked the Michigan Delegation to the AMA to request the AMA to develop a reasonable set of uniform and effective criteria for use by the growing number of third party and free standing review organizations.

The intent of this resolution was incorporated into a resolution introduced by the Michigan Delegation to the AMA at the AMA Interim Meeting December 3-6 in Hawaii. The Michigan resolution was grouped with two others regarding PRO and Medicare screening requirements. The AMA House of Delegates adopted AMA Report PP, "AMA Initiative on Medical Review," in lieu of the resolutions. The Report calls for streamlining and reducing duplication in the review programs, and promoting uniformity and consistency across reviewing entities.



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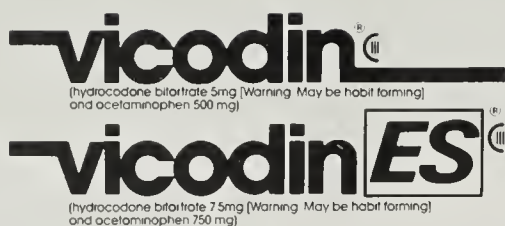
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1. Data on file, Knoll Pharmaceuticals

2. Standard industry new prescription audit.

Please see adjacent page for brief summary of prescribing information.



INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS:

Allergic-Type Reactions: VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy:

Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

Labor and Delivery: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

Gastrointestinal System: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

DRUG ABUSE AND DEPENDENCE:

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution.

OVERDOSAGE:

Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised June 1989 Knoll Pharmaceuticals
A Unit of BASF K&F Corporation
Whippany, New Jersey 07981



35-89A

Title: Selection for Mediation Panel. Adopted as Amended.

This resolution asked that MSMS seek a change in the method of selecting physicians to serve as mediators in malpractice litigation. At present each party to the case selects one of the two physician mediators. The House of Delegates wants these mediators to be selected by an administrative court process instead of the litigants.

The Task Force on Professional Liability discussed this matter with Legal Counsel who advised that (1) any change in the selection of mediators would require a change in Supreme Court rules and (2) it would be premature to seek changes in the Supreme Court rules until after the Courts throughout the State have had more experience with the mediation process in malpractice cases. The Task Force will continue to keep this resolution active on its agenda.

36-89A

Title: Lapel Pins for AMA Membership. Adopted.

This resolution asked the Michigan Delegation to the AMA to ask the AMA to develop a coat lapel pin for doctors who are members of their county medical society, state medical society, and the AMA.

AMA Resolution 143 (A-89) was introduced by the Michigan Delegation at the June Annual Meeting of the AMA. Reference Committee F recommended non-adoption of the Resolution and the House of Delegates adopted the recommendation.

37-89A

Title: Fragmented Care. Substitute Resolution (in lieu of 37-89A, 105-89A). Adopted.

This resolution asked MSMS, the Michigan Peer Review Organization (MPRO) and Michigan Hospital Association (MHA) to develop procedures to address the issues of fragmented care; and that MSMS remind the Health Care Finance Administration (HCFA) that fragmented care issues do not of themselves imply that standards of care have not been met; and that the Michigan Delegation to the AMA encourage AMA to improve HCFA guidelines for fragmented care.

The MSMS Liaison Committee with MPRO discussed this matter with Representatives of Blue Cross Blue Shield of Michigan, Michigan Hospital Association, and Michigan Peer Review Organization. MSMS learned that HCFA documents and reports indicate HCFA's position that fragmented care is not a quality of care issue but rather a billing issue. The MSMS Committee has recommended to the Board of Directors that the MPRO Board of Directors condense the HCFA reports into a easily read and received document for distribution to Michigan physicians and Michigan hospitals.

38-89A

Title: II. The Quality Intervention Plan (QIP). Adopted as Amended.

This resolution asked the Michigan Delegation to the AMA to request that the AMA recommend to HCFA that changes be made in QIP that reflect:

a) Quality indicators should be made only by physicians and notification to physicians should be made when each level of alleged mismanagement is determined.

b) "Significant adverse effect" must be more narrowly defined so that individual physicians can evaluate his/her care of patients as it may relate to these regulations.

c) Practicing physicians, not affiliated with MPRO should assist in the development of the definition of the circumstances under which MPRO would voluntarily share its confidential information regarding a physician with a licensing or accreditation body when no request for information has been received.

The resolution further asked that MSMS pursue educational activities to apprise physicians of the implications of the indexing system of QIP and the potential disciplinary actions that can result.

AMA Resolution 68 (I-89) was introduced by the Michigan Delegation at the December Interim Meeting of the AMA. It was referred to the AMA Board of Trustees for report back at the 1990 Annual Meeting. Because the issue of QIP is national in scope, the Resolution also asked that the AMA assume the role of informing physicians of the implications of the QIP indexing system and the potential for disciplinary actions that can result.

9-89A	Title: Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). Referred to the Board for study. Resolution 39-89A requested that the Michigan Delegation to the AMA urge the AMA to respond to OBRA of 1987 by recommending that this Act be either modified or rescinded with the goal of finding a reasonable solution; hospitals, third party reimbursers, nursing homes, and community health boards all must share a part of the financial burden of caring for long-term care patients undergoing the preadmission screening process. The MSMS Committee on Aging has studied and critiqued the OBRA 1987 Preadmission Screening and Annual Resident Review Program (PASARR) for nursing home patients with the Michigan Department of Mental Health making significant recommendations. At its June 1989 meeting, the AMA House of Delegates adopted a resolution calling for the repeal of the PASARR Program. MSMS believes that because of strong concerns for the nursing home patient and the preadmission screening and annual resident review (PASARR) process by MSMS and AMA physicians, there will continue to be federal implementation guidance changes to OBRA.		This resolution called for MSMS efforts to change existing requirements for hospitals wishing to designate beds as swing beds for short term nursing care. Reforms to Michigan's Certificate of Need system enacted late in 1988 permit hospitals with fewer than 100 licensed beds to designate beds for short-term nursing care in certain instances. The Certificate of Need Commission will undertake a review of nursing care bed needs early in 1990, and will make recommendations for policy changes to meet both long-term and short-term nursing care needs. MSMS will work with the Commission to suggest statutory and policy changes permitting swing bed designation by hospitals with more than 100 licensed beds.
44-89A	Title: Obstetrical Swing Beds for Clean Gynecological Surgical Patients. Adopted. This resolution asked MSMS to request an administrative decision from the Michigan Department of Public Health, allowing hospitals with an occupancy rate of less than 85 percent to establish swing beds for clean gynecological patients in obstetrical departments. MSMS has requested the MDPH Bureau of Health Facilities to review their existing policy, and is currently awaiting their response. In the meantime, Representative Nancy Crandall has introduced legislation, HB 5539, which would change Michigan's statute regarding swing beds to reflect the MSMS position. HB 5539 is currently pending in the House Public Health Committee.		
0-89A	Title: Notification of Medical Staff When There is to be Change of Hospital Governance. Adopted. This resolution asked that MSMS encourage the Michigan Hospital Association (MHA) to request its members to inform medical staffs at the earliest appropriate time (at least 60 days) before mergers, acquisitions or closures. The MSMS Hospital Medical Staff Section Representatives and Governing Council have studied existing Federal law regarding "The Worker Adjustment and Retaining Notification Act," and State Legislation which has been proposed. An action report has been approved by the MSMS Board of Directors requesting that the Michigan Hospital Association Board of Directors encourage the Governing Body and Administration of their member hospitals to advise the medical staff minimally 60 days before, but not limited to, a hospital closing, acquisition, merger, affiliation or reduction in primary or ancillary service.	45-89A	Title: Physicians Recovery Network. Substitute Resolution (in lieu of 45-89A, 50- 89A, 56-89A and 119-89A). Adopted. This resolution asked the Board to find a source of funds to accomplish the objectives of the Physicians Recovery Network and to revitalize its activities. The Budget Development Committee and the Finance Committee gave careful considerations to this resolution and recommended that the Physicians Recovery Network budget be increased from \$55,800 in FY 1989 to \$79,200 in FY 1990. The Board approved this increase in FY 1990 Operating Budget.
1-89A	Title: Peer Review Organization Physician Reviewer Qualifications. Substitute Resolution (in lieu of 41-89A and 123-89A). Adopted. This resolution requested that MSMS request the specialty societies to develop qualifications for PRO specialty specific physician reviewers; that MSMS utilize its influence to cause MPRO to implement these specialty-specific physician reviewer qualifications; that sanctions against physicians be reviewed by the same specialty or subspecialty; and that the MSMS Liaison Committee with MPRO encourage Michigan Chapters of Specialty Societies to cooperate and encourage qualified specialists to become MPRO Physician Reviewers. The MSMS Liaison Committee with MPRO submitted an action report approved by the MSMS Board of Directors calling for the implementation by the MPRO Board of Directors of an expanded MPRO Physician Reviewer Application which would cause the resolve portions of this resolution to be effected. The Committee has submitted a companion action report to the MSMS Board of Directors calling for the MSMS Board to encourage the Blue Cross Blue Shield of Michigan to implement a similar Physician Reviewer Application.	46-89A 47-89A	Title: Guidelines of Care. No Action. Title: Bicycle Helmets. Adopted as Amended. This resolution endorsed the use of ANSI or SNELL approved helmets for all bicycle riders and passengers and directed MSMS to undertake an educational campaign to promote the safety advantages of bicycle helmet use. The Advisory Committee on Communications and Professional Relations plans to include the message about bicycle helmet use in one of the public service announcements for the CARING Campaign during the spring and summer of 1990.
48-89A	Title: Peer Review Organization (PRO) Quality Denial Letters. Substitute Resolution (in lieu of 48-89A, 60-89A and 116-89A). Adopted. This resolution asked the Michigan Delegation to the AMA to request the AMA to do the following: a) Take whatever action necessary to change the proposed "Quality Denial Model Letter." b) Request that HCFA issue quality denial letters only when the review process has been completed and when the attending and/or consulting physician have been afforded due process. c) Request HCFA to notify all involved parties by letter immediately if the denial is overturned in those cases in which the denial letter is sent prior to completion of due process. d) Request that HCFA state in any denial letter sent prior to the completion of due process, that the MPRO determination is subject to review and may be reversed. The Michigan Delegation to the AMA did not forward this resolution to the AMA House of Delegates because it was aware of existing AMA policies which address the concerns raised. Specific reference to AMA		
2-89A	Title: Medicare Catastrophic Care Coverage. Adopted. This resolution asked the Michigan Delegation to the AMA to request the AMA to work with Congress to extend DRG reimbursement for those patients whose hospitalization is prolonged because of the Medicare Catastrophic Coverage Act. The Michigan Delegation to the AMA had planned to submit a resolution on this issue at the December Interim Meeting but did not because the Medicare Catastrophic Coverage Act was repealed by Congress in November.		
3-89A	Title: "Short-Term Nursing Care" Swing Beds for Hospitals That are Licensed for More than 100 Beds. Adopted.		

- negotiations with HCFA regarding "quality denial" regulations are detailed in the Council on Medical Service Report P (A-89), "Peer Review Program Organization Status."
- 49-89A **Title: Terminology Used by Fiscal Intermediary on Medicare Voucher.** Adopted as Amended.
- This resolution asked the Michigan Delegation to the AMA to recommend that the AMA encourage the Health Care Finance Administration (HCFA) to change wording on the Medicare voucher from "Reasonable Charge" to "Allowed Amount."
- AMA Resolution 145 (A-89) was introduced by the Michigan Delegation at the June Annual Meeting of the AMA House of Delegates. It was amended and adopted by the House as follows:
- RESOLVED, That the American Medical Association encourage the Health Care Financing Administration to change wording on the Medicare voucher from "Reasonable Charge" to "Covered Amount."
- 50-89A **Title: Adequate Financing of the MSMS Program to Assist Impaired Physicians.** Substitute Resolution (in lieu of 45-89A, 50-89A, 56-89A and 119-89A). Adopted. See Resolution 45-89A.
- 51-89A **Title: Improving Teen Sex Education.** Substitute Resolution (in lieu of 51-89A, 108-89A, 121-89A and 125-89A). Adopted.
- This resolution called for continued MSMS support of public funding for sex and reproductive education programs for teens and for expanded efforts to educate teens about sexually transmitted diseases.
- Existing law requires sex and reproductive education programs to include information about AIDS and other sexually transmitted diseases. MSMS will continue its support of public funding for these programs in upcoming state budget deliberations. MSMS also is being asked to participate in revisions of Department of Education guidelines for reproductive education in schools and in the review and revision of the Michigan Model for School Health. MSMS will work to ensure these guidelines and models include sufficient information about sexually transmitted diseases.
- 52-89A **Title: Breakaway Bases for Baseball.** Adopted.
- This resolution directed MSMS to work with interested groups to emphasize the need for breakaway bases. It was referred to the Advisory Committee on Communications and Professional Relations, which is having trouble developing avenues of action. Committee members have come to the point that they will talk again with the resolution's introducer to gather further views on how best to proceed.
- 53-89A **Title: Illegal Drugs and Affect on America.** Disapproved.
- 54-89A **Title: Basic Information Regarding Facts of Minimum Health Insurance Coverage for Senior Citizens.** Adopted.
- This resolution directed MSMS to work with the Michigan Insurance Bureau in the development of informational materials regarding Medicare supplemental insurance.
- The MSMS Committee on Aging has reviewed "The Senior Consumer Alert", published by the American Association of Retired Persons in 1987, which explains the minimum coverage for Medi-Gap Insurance. MSMS will work with the Insurance Commissioner to produce a similar document for Michigan consumers.
- 55-89A **Title: Prohibit the Promotion of Tobacco.** Adopted.
- This resolution adopted the position that tobacco promotion, by any means, be made illegal in a similar manner to that which currently exists for electronic media and asked the Michigan Delegation to the AMA to urge the AMA to adopt a similar position.
- The Michigan Delegation to the AMA did not forward this resolution because it was aware that current AMA policy, as reflected in a "Tobacco-Free Society by the Year 2000," includes proposed legislation to ban advertisement of tobacco products. The AMA Board of Trustees was directed by the House of Delegates in 1987 to give progress reports at each Interim Meeting until the year 2000.
- 56-89A **Title: Funding Proposal for Physician Recovery Network.** Substitute Resolution (in lieu of 45-89A, 50-89A, 56-89A and 119-89A).
- Adopted. See Resolution 45-89A.
- 57-89A **Title: Restrictions on Performance of Autopsies.** Adopted as Amended.
- This resolution asked that MSMS oppose House Bill's 4161-4162 that would establish religious objections as grounds for denial of the performance of an autopsy.
- In October 1989, MSMS testified before the House Public Health Committee in opposition to HB's 4161-62. The House Public Health Committee has delayed further action on these bills due to lack of support in Committee. MSMS will continue to aggressively oppose HB's 4161-62.
- 58-89A **Title: BCBSM Reimbursement Levels.** No Action.
- 59-89A **Title: Landfill Violations.** Disapproved.
- 60-89A **Title: MPRO Letters Questioning the Quality of Care.** Substitute Resolution in lieu of 48-89A, 60-89A and 116-89A). Adopted. See Resolution 48-89A.
- 61-89A **Title: Federal Licensure Legislation.** Adopted as Amended.
- This resolution asked the Michigan Delegation to the AMA to ask the AMA to support legislation that bans discrimination in licensure, licensure by endorsement, jobs, promotions, hospital privileges, reimbursement, residency medical staff and academic appointments, professional society memberships, financial aid and board certification solely on the basis of being a graduate of a foreign medical school.
- AMA Resolution 70 (I-89) was submitted by the Michigan Delegation at the December Interim Meeting. It was referred to the Board of Trustees for further study.
- The AMA Board of Trustees referred the resolution to the AMA Council on Medical Education. Chairman Busharat Ahmad, MD, and Vice Chairman Krishna K. Sawhney, MD, of the MSMS Section for Graduates of Foreign Medical Schools, testified before the Council at a January 7, 1990 hearing. The Council is to report to the AMA House of Delegates at the June 1990 meeting.
- The AMA Board of Trustees referred the resolution to the AMA Council on Medical Education. Chairman Busharat Ahmad, MD, and Vice Chairman Krishna K. Sawhney, MD, of the MSMS Section for Graduates of Foreign Medical Schools, testified before the Council at a January 27, 1990 hearing. The Council is to report to the AMA House of Delegates at the June 1990 meeting.
- 62-89A **Title: International Cooperation in Medical Education.** No Action.
- 63-89A **Title: Graduates of Foreign Medical Schools Involvement in the AMA.** Adopted.
- This resolution asked the Michigan Delegation to the AMA to recommend that the AMA encourage more involvement of graduates of foreign medical schools in its policy-making.
- AMA Resolution 144 (A-89) was introduced by the Michigan Delegation at the June Annual Meeting of the House of Delegates and adopted. Subsequently, the AMA formed an Advisory Committee on Foreign Medical Graduates and appointed Busharat Ahmad, MD, Marquette, its first chairman.
- 64-89A **Title: Discrimination in Residency Programs.** Referred to the Board for study.
- This resolution directed MSMS to study practices of graduate medical education programs in Michigan with regard to acceptance of graduates of foreign medical schools, and calls on MSMS to establish programs to help graduates of foreign medical schools apply and interview for residency programs.
- Board Chairman Frank B. Walker, MD, appointed a task force to carry out this directive. The Task Force, chaired by James L. Fenton, MD, has surveyed all residency program directors in the state, asking about their practices for naming physicians to openings. Fifty percent of the residency program directors responded to the survey. Based on their responses, the Task Force members recommended MSMS ask residency program directors to apply standards equally to all applicants, and not to discriminate against applicants strictly because they are graduates of

	foreign medical schools. They call on MSMS to ask the AMA to seek an end to pressures from national accrediting and funding groups which discourage programs from placing graduates of foreign medical schools in their residency positions. And they recommend that MSMS hold seminars to help graduates of foreign medical schools apply for residency positions.	
	The Board concurred with the Task Force recommendations.	
5-89A	Title: Support for the General Accounting Office Study. Adopted as amended.	
	This resolution directed the Board to indicate to the US General Accounting Office (GAO), the willingness of MSMS and the newly- formed Graduates of Foreign Medical Schools Section to offer assistance and input to the GAO study, Discrimination Against Graduates of Foreign Medical Schools in Training and Practice. The Board authorized the sending of an appropriate letter to the GAO.	
6-89A	Title: MSMS Assistance in Locating Residencies. Adopted as amended.	
	This resolution called for MSMS assistance in locating residencies left vacant after residency matching is completed and making the information available as quickly as possible.	
	The Michigan Council on Graduate Medical Education has been collecting and maintaining this type of information for approximately the past four years and MSMS has a delegate, alternate delegate and staff assigned to maintain liaison. Informal discussion about utilizing the information collected already was positive and the matter will be placed on the agenda for formal discussion at the next meeting of MCGME, scheduled for May 2, 1990.	
7-89A	Title: Commendation to the Michigan Legislature for Passage of Pension Plan Protection Legislation. Substitute Resolution (in lieu of 67-89A, and 149-89A). Adopted.	
	This resolution directed MSMS to write letters of appreciation to the Governor and members of both houses of the Legislature for passage of the Pension Protection Legislation.	
	Letters of appreciation have been sent to the Governor and leaders of both Houses of the Michigan Legislature commending them for passage of Pension Protection Legislation. This action had been delayed to see if any challenges might be made as to the constitutionality of the legislation as has happened with similar legislation in Texas, but no challenge has surfaced in Michigan. MSMS staff and legal counsel continue to monitor the challenge in Texas for possible ramifications in Michigan.	
8-89A	Title: Required Hepatitis Vaccination Financing. Adopted as amended.	
	This resolution called for MSMS to encourage use of hepatitis B vaccine for all at risk individuals, and to encourage the state to provide funding for hepatitis B vaccine for indigent and Medicaid patients.	
	Exploration of state policies reveal that local health departments are currently providing hepatitis B vaccine for indigent individuals, as is the Medicaid program. MSMS will continue to inform members about the risks of hepatitis B, so physicians can immunize their patients who may be at risk. MSMS also is monitoring proposed federal occupational safety and health regulations which would require health facilities to immunize their employees.	
9-89A	Title: Medical Liability Insurance Carriers to Provide Legal Counsel at MPRO Hearings. Referred to the Board.	
	This resolution called for medical liability insurance carriers in the state of Michigan to offer at no cost to the physician a rider to the physicians insurance policy that would provide legal counsel at MPRO hearings when needed.	
	The MSMS Liaison Committee with MPRO investigated this possibility with medical liability insurance carriers in Michigan and submitted a report in lieu of this Resolution which was approved by the MSMS Board of Directors indicating no legal counsel coverage is available at this time and would not be available without an increased premium.	
70-89A	Title: Abortion. No Action.	
71-89A	Title: Opposition to the Use of Infant Walkers. Substitute Resolution (in lieu of 71-89A and 74-89A). Adopted.	
	This resolution directed MSMS to discourage the use of infant walkers, to encourage physicians to counsel parents of the significant risk of injury from infant walkers and to distribute an informational handout through <i>Medigram</i> and <i>Michigan Medicine</i> . The resolution also asks the Michigan Delegation to the AMA to recommend a similar position.	
	AMA Resolution 146 (A-89) was introduced by the Michigan Delegation at the June Annual Meeting. In addition to policy statement, the resolution asked the AMA to develop informational materials and make them available to physician associations and other organizations. The Resolution was referred to the Board of Trustees for report to the House of Delegates at the 1990 Annual Meeting.	
72-89A	Title: Health Insurance Options Excluding Maternity Benefits for MSMS Members. Substitute Resolution (in lieu of 7-89A, 27- 89A and 72-89A). Adopted. See Resolution 7- 89A.	
73-89A	Title: "MSMS Policy re Michigan is a Bad State to Practice Medicine." Disapproved.	
74-89A	Title: Opposition to the Use of Infant Walkers. Substitute Resolution (in lieu of 71-89A and 74-89A). Adopted. See Resolution 71-89A.	
75-89A	Title: Graduate Medical Education Funding in Michigan. Adopted as amended.	
	This resolution asked that MSMS actively promote adequate funding of all graduate medical education since GME has been targeted for cuts in the Medicaid budget for the past several years.	
	Through its representatives to Michigan Council on Graduate Medical Education and Michigan Association for Medical Education, MSMS gave oral and written testimony to the Legislature outlining the threat to health care services for the poor and underserved population. MSMS was successful in 1989 in helping to forestall the cuts, but it is anticipated the same situation will arise again. MSMS, through its MCGME representatives and the Michigan Delegation to the AMA, will continue to monitor the issue and is prepared when necessary to testify and provide data regarding the provision of health care by residents. The MSMS position focuses on cuts in care rather than financial issues.	
76-89A	Title: AMA Journal Policy. Adopted.	
	This resolution called upon the Michigan Delegation to the AMA to ask the AMA to reinstate specialty journal privileges to all member physicians who request reinstatement.	
	The Michigan Delegation to the AMA did not forward this resolution because many similar resolutions have been introduced during meetings of the House of Delegates since the circulation pattern for specialty journals was changed in 1988. At the June Annual Meeting, the House adopted Board of Trustees Report XX (A-89) which explained that the circulation change was the only option that allowed the AMA to avoid substantial operating deficits for these journals.	
77-89A	Title: Identification of Tobacco Use as Drug Abuse. Disapproved.	
78-89A	Title: Universal Insurance Forms. No action.	
79-89A	Title: No-Fault Legislation Proposal for Medical Malpractice. No action.	
80-89A	Title: Disposal of Low-level Radioactive Waste. Substitute Resolution (in lieu of 80- 89A and 81-89A). Adopted.	
	This resolution called for MSMS to become involved in the radioactive waste disposal site selection process to assure appropriate consideration of public health and environmental concerns related to waste disposal.	
	MSMS has obtained representation on both the Michigan Coalition of Radioactive Materials Users and the MDPH Low-Level Radioactive Waste Advisory Committee. Both groups will be instrumental in decisions relating to radioactive waste disposal in Michigan. MSMS also is currently monitoring several legislative efforts related to Michigan participation in the low-level radioactive waste disposal compact.	

One section of this resolution asked the Michigan Delegation to the AMA to request the AMA to call for evaluation of national policy regarding low-level radioactive waste disposal and to seek development of a coordinated national policy for the disposal of low-level radioactive waste.

The Michigan Delegation to the AMA did not forward this resolution because of its belief that Council on Scientific Affairs Report A (I-88) had addressed the issue.

81-89A **Title: Low Level Radioactive Waste Disposal.** Substitute Resolution (in lieu of 80-89A and 81-89A). Adopted. See Resolution 80-89A.

82-89A **Title: Publishing Names of Expert Witness.** Disapproved.

83-89A **Title: Office Practice Management Assistance.** No action.

84-89A **Title: Forfeiture.** Adopted.

This resolution asked MSMS to support legislation that would permit forfeiture of real property used in committing a violation of the Substance Abuse Act and that MSMS lobby to have 50 percent of forfeiture proceeds be used for community-based educational and substance abuse treatment programs.

Substance abuse legislation was introduced in the legislature in 1989 that provided specific penalties for possession of a controlled substance. An amendment sought by MSMS that would permit the forfeiture of real property used in committing a violation of the Substance Abuse Act was defeated on the House floor. MSMS will continue to urge passage of this provision.

85-89A **Title: School Based Family Planning.** Substitute Resolution (in lieu of 12-89A, 85-89A and 126-89A). Adopted. See Resolution 12-89A.

86-89A **Title: Study of Health Care Delivery to Minorities in Michigan.** Adopted as amended.

This resolution directed MSMS to work with the Michigan Department of Public Health in addressing disparities in medical care delivery to minorities.

In November, 1989, the MDPH established an Office of Minority Health. MSMS has discussed cooperative efforts with the Director of the office, which will include sharing statistical information, education about health risks and addressing the needs of uninsured minorities.

One section of this resolution asked the Michigan Delegation to the AMA to encourage the AMA to continue monitoring medical care delivery to minority populations on the national level.

The Michigan Delegation to the AMA has transmitted this message to the AMA Council on Medical Service.

87-89A **Title: Commendation for Roger F. Mecum.** Adopted.

This resolution directed that appropriate letters of commendation for Roger Mecum be forwarded and this has been done.

88-89A **Title: Necessary Testing in the Physician's Office.** Referred to the Board for study.

This resolution asked MSMS to oppose any new legislation which limits office testing by physicians.

The Committee on Medical Licensure and Discipline reviewed this resolution. Currently, there is no pending state legislation that would restrict physician office testing. MSMS will closely monitor any legislation that may be introduced on this issue.

One section of this resolution asked the Michigan Delegation to the AMA to request the AMA to oppose any legislation which limits physician's office testing done in the necessary evaluation of the patient.

The AMA Delegation has requested that the AMA monitor any regulations passed by Congress regarding physicians' office testing.

89-89A **Title: Freedom of Choice for the Poor.** Adopted as amended.

This resolution directed MSMS to promote freedom of choice and continuity of care in the development of plans providing health care services for the indigent.

With MSMS support, the Michigan Medicaid program continues to offer Medicaid clients several options for medical care, including fee-for-service, HMOs where available, and other managed care programs. The Governor's Task Force on Access to Health Care will also recommend the development of health care plans for the indigent which provide as broad a range of health care plans as possible.

90-89A **Title: Durable Medical Goods.** Adopted as amended.

This resolution requested that MSMS seek legislation to restrict solicitation of prescription for durable medical goods from licensed health care providers and that MSMS inform physicians of the high costs that result from the promotion of durable medical goods.

MSMS currently is working to seek a sponsor for legislation to restrict solicitation of prescriptions for durable medical goods. MSMS also is working to identify specific cases of solicitation of prescriptions for durable medical goods from physicians.

One section of this resolution asked the Michigan Delegation to the AMA to ask the AMA to seek federal legislation to restrict solicitation by durable medical goods vendors, and pursue a national information campaign for physicians.

AMA Resolution 147 was introduced by the Michigan Delegation at the June Annual Meeting of the AMA. It was considered together with Resolution 93 and resulted in House adoption of Substitute Resolution 93 in lieu of Resolutions 93 and 147:

RESOLVED, That the American Medical Association disapprove of product-specific marketing of prescription drugs, devices and infant formula directly to the public and make its reasons for this position known to manufacturers and citizens; and be it further

RESOLVED, That the AMA seek legislation or regulation to restrict direct patient solicitation by durable medical goods companies in all instances where payment is contingent upon the certification of necessity by a physician ("by prescription"); and be it further

RESOLVED, That the AMA establish as policy that such durable medical goods may be obtained only when certification of necessity (prescription) is initiated by a physician; and be it further

RESOLVED, That the AMA educate physicians regarding issues relevant to the inappropriate promotion by manufacturers of durable medical goods and the contribution of such promotion to the unnecessary expenditure of health care dollars.

91-89A **Title: Anabolic Steroid Use.** Adopted.

This resolution asked MSMS to seek state legislation to restrict anabolic steroids by means similar to those in effect for amphetamines and to support legislative efforts to restrict the distribution of steroids and make possession of steroids for other than medically recognized purposes a felony.

MSMS was successful in its efforts to pass House Bill 4081, a bill that makes it illegal to sell, possess, or use steroids without a lawful prescription. House Bill 4081 was signed into law on March 13, 1990, as Public Act #30.

This resolution also asked the Michigan Delegation to the AMA to ask the AMA to seek federal measures to restrict the distribution of anabolic steroids.

AMA Resolution 152 (A-89) was introduced by the Michigan Delegation at the June Annual Meeting of the House of Delegates and was referred to the Board of Trustees. It resulted in Report A (I-89) of the Council on Scientific Affairs, "Medical and Nonmedical Use of Anabolic-Androgenic Steroids." It was referred to Reference Committee E and adopted by the House in lieu of Resolution 152 (A-89) at the December Interim Meeting.

92-89A **Title: Opposition to Centralized Post Graduate Medical Education.** Adopted.

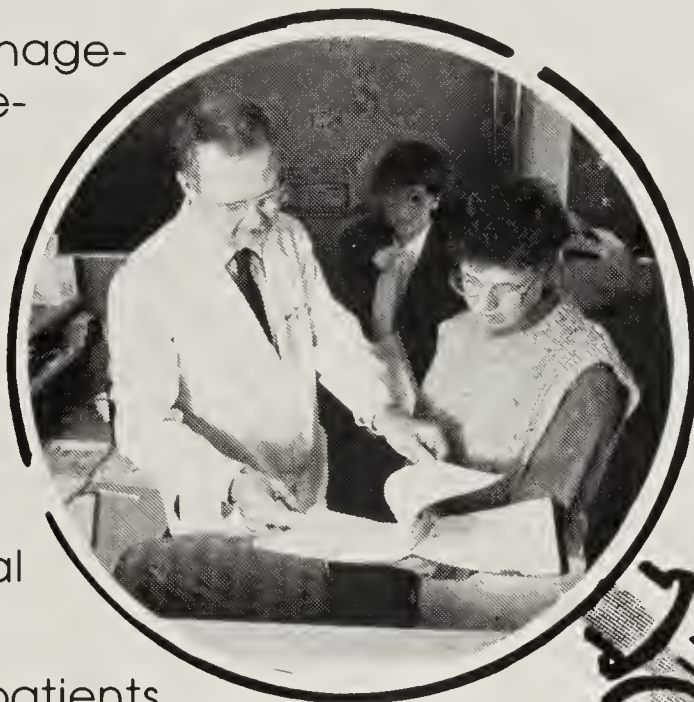
This resolution called for MSMS to continue to support a pluralistic system of postgraduate medical education for house officer training and also to oppose the mandatory centralization of postgraduate medical

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The Stratton-Cheeseman Office Risk Analysis examines your office under glass.

Our trained risk management consultants re-view your...

- billing practices
- medical records
- physical layout
- drug dispensing
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training under the auspices of the nation's medical schools.

The Michigan Council on Graduate Medical Education and the Michigan Medical Schools Council of Deans have discussed this issue and the two groups have a position which is in strong agreement with this MSMS resolution. MSMS continues to monitor the issue and support the resolution through its MCGME representatives.

One section of this resolution asked the Michigan Delegation to the AMA to ask the AMA to take similar action as the MSMS House by continuing to support a pluralistic system of post graduate medical education for house officer training and by opposing the mandatory centralization of post graduate medical training under the auspices of the nation's medical schools.

AMA Resolution 69 (I-89) was introduced by the Michigan Delegation at the December Interim Meeting of the AMA House of Delegates and adopted.

93-89A **Title: Medical Student Membership in Organized Medicine.** Adopted.

This resolution requested MSMS to develop and offer a single state and county membership fee for medical students for all four years of medical school. This year the MSMS student application does indicate that a one-time payment of \$45 is offered to all first year medical students. The fee covers County and State dues for all four years of medical school. A total of ten medical students took advantage of this opportunity this year.

94-89A **Title: County Medical Society Structure.** Adopted.

This resolution asked the Michigan Delegation to the AMA to request the AMA to make the WCMS election strategy and bylaws available for appropriate dissemination and usage by large county medical societies in order to enhance the democratic and leadership process.

The availability of the Wayne County Medical Society election bylaws has been made known through the auspices of the American Association of Medical Society Executives.

95-89A **Title: Improving the Medicaid Program.** Substitute Resolution (in lieu of 95-89A and 143-89A). Adopted.

This resolution called for MSMS to seek a review of Medicaid reimbursement levels and to work jointly with other health associations to draw attention to the problem of inadequate Medicaid reimbursements.

MSMS is working with MAOP&S in the development of informational materials for distribution to members, legislators and the media regarding physician participation in the Medicaid program. The MSMS Medicaid Liaison Committee is also considering alternative strategies for pursuing reimbursement relief, possibly through litigation. MSMS has been active in efforts on the part of Medicaid officials to explore the Resource Based Relative Value Scale as a means of improving Medicaid payments to physicians.

96-89A **Title: Physician/Hospital Joint Ventures.** Disapproved.

97-89A **Title: Publication of Disciplinary Actions of the Michigan Board of Medicine.** Referred to the Board for study.

This resolution requested that MSMS review actions of the Michigan Board of Medicine that are proposed to be printed in *Michigan Medicine* and render a decision as to appropriate publication of consent and stipulation of orders of reprimand.

The MSMS Committee on Licensure and Discipline referred this matter to the MSMS Committee on Publications. After commentary from the Board of Medicine's point of view from MSMS legal counsel, the Board supported the Committee's recommendation that *Michigan Medicine* print all Board of Medicine actions except those which only reprimand physicians.

98-89A **Title: Opposition to Mandatory Malpractice Insurance.** Adopted as amended.

This resolution asked that MSMS strongly oppose legislation that would require mandatory malpractice insurance.

Over the past few years, several legislative attempts have been made to mandate physicians to carry malpractice insurance. MSMS has been successful in defeating these attempts.

On March 7, 1989, Senator Jack Faxon introduced Senate Bill 185, that would require mandatory malpractice insurance for licensure in Michigan. Currently, SB 185 is before the Senate Judiciary Committee. Thus far, MSMS has been successful in delaying any action on SB 185 in committee. MSMS will continue to aggressively oppose SB 185 and any other similar legislation that may be introduced.

99-89A **Title: Commendation of Northwest Airlines.** Adopted.

This resolution commended Northwest Airlines for its public health policy of prohibiting tobacco smoking on all its domestic routes in the contiguous USA and directed MSMS to present an appropriate Recognition Award to Northwest Airlines commending their "no smoking" policy.

This resolution was referred to the Advisory Committee on Communications and Professional Relations which has sent a letter of commendation to the Airline.

100-89A **Title: Ban the Sale and Ownership of Assault Weapons Originally Designed Primarily for Human Destruction.** Amended Substitute Resolution (in lieu of 100-89A, 117-89A and 141-89A). Adopted as amended.

This resolution asked MSMS to seek legislation to ban the sale or ownership of assault weapons in Michigan, with the exception of the armed forces or the police.

House Bill 4624 would ban the sale or use of automatic assault rifles. The Bill is in the State Affairs, Tourism and Transportation Committee. No hearings have been held. MSMS will work with sponsors of this legislation in seeking its passage. However, it may not be politically feasible to enact such legislation at this time.

This resolution also directed MSMS to support efforts to limit ownership and use of assault weapons and to seek legislation to ban the sale or ownership of assault weapons in Michigan, with the exception of the armed forces and the police. It also asked the Michigan Delegation to the AMA to urge the AMA to state a position favoring similar legislation at the Federal level and to exert strong efforts in Washington to achieve passage of such legislation and more effective handgun control.

AMA Resolution 148 (A-89) was introduced by the Michigan Delegation at the June Annual Meeting of the AMA House of Delegates. It was considered together with Resolution 264 and the House adopted the following Substitute Resolution 264 in lieu of Resolutions 148 and 264:

RESOLVED, That the American Medical Association support appropriate legislation that would restrict the sale and private ownership of large clip, high-rate-of-fire automatic and semi-automatic firearms or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon.

101-89A **Title: BCBSM Fee Schedules in Different Practice Settings.** Amended and referred to the Board for study.

This resolution asked MSMS to evaluate and review problems of different fees for the same procedures. BCBSM and MSMS were requested to develop a more accurate payment system.

MSMS met several times in Western Michigan on this issue as well as with our MSMS/BCBSM Liaison Committee. Our Physicians Advisory Committee Members to Blue Cross Blue Shield have addressed this issue as well during the Fall of 1989.

The resolution was discussed at the January 10, 1990, meeting of the Committee. MSMS staff was directed to request specific examples of the differing fees from the physician who introduced the resolution and to then discuss BCBSM policy with Doctor Fred Severyn.

BCBSM initiated an "ambulatory surgical incentive" program in 1983, which provided reimbursement incentives to perform certain surgical procedures on an outpatient basis. These procedures were reimbursed at 100 percent maximum screen for ambulatory setting, at 110-112 per-

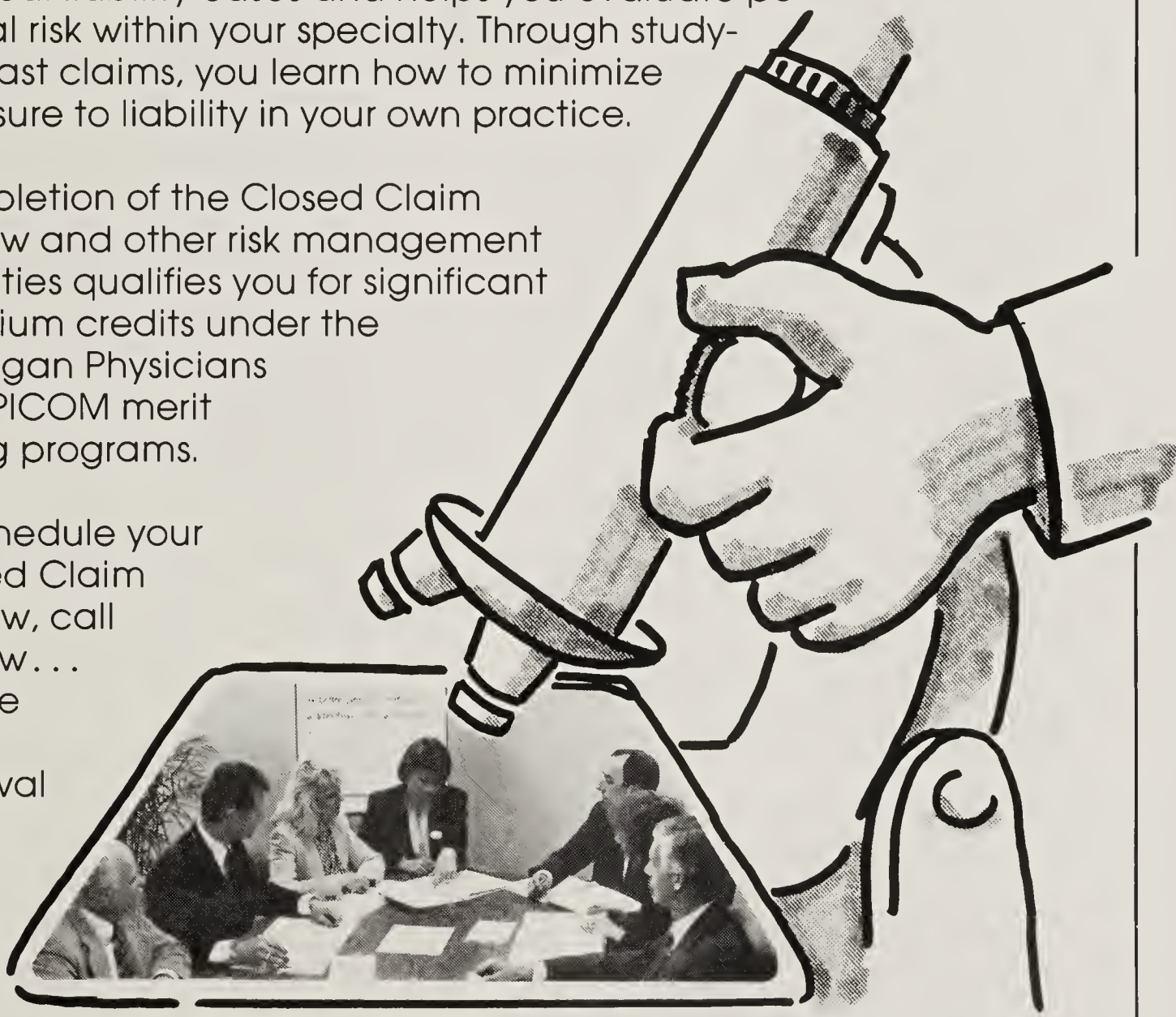
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cent in the office setting and at a lower than 100 percent level in the hospital setting.

The program was expanded in 1988. Twenty physicians representing various specialty groups reviewed 1,100 procedures to determine which ones should be performed in an out-patient setting. Of these, about 300 procedures were selected for inclusion on the ambulatory surgical incentive list. A procedure was selected if it was performed at least 100 times per year and performed 75 percent of the time in the physician's office. Exceptions for in-patient settings are made for extremely ill patients.

An April 1, 1988, BCBSM directive with the preceding information was sent to all physicians and hospitals.

MSMS should continue to support equitable payment for the same procedure. To address the issue of equitable payment, the Committee needs specific information from physicians in order to facilitate communication with BCBSM.

102-89A Title: Cost of Inpatient Case Activities. Adopted as amended.

This resolution asked the Michigan Delegation to the AMA to request the AMA to do the following:

a) Work with the Health Care Finance Administration (HCFA) to reduce the onerous demands for medical records and chart review currently being performed.

b) Work with HCFA to reduce or clearly demonstrate that a 25 percent case review is necessary to identify both care and utilization issues.

c) Inform Congress about the burden imposed on hospitals in the face of cost containment measures.

AMA Resolution 67 (1-89) was introduced by the Michigan Delegation at the December Interim Meeting of the AMA House of Delegates. It was considered along with Resolutions 67, 179 and Report PP of the Board of Trustees, "AMA Initiative on Medical Review." The Report calls for the AMA to work with HCFA to reduce the demands for review of medical records and charts and to seek significant changes in medical review processes to eliminate waste and frustration for both patients and physicians. The House adopted Report PP as amended in lieu of Resolutions 67, 88 and 179.

103-89A Title: Impaired Physician and the Board of Medicine. Adopted.

This resolution requested that MSMS work for the enactment of legislation that would allow the Board of Medicine to handle impaired physicians in confidence and to utilize impaired physician programs available from MSMS and others.

MSMS supports House Bill 4712, which would permit a health services licensing board, in agreement with an association of health professionals, to establish an impaired health professional committee to address health professionals' drug abuse and dependency. MSMS will continue to work with the sponsor of HB 4712 to secure enactment of the legislation.

104-89A Title: Medicaid Inpatient Case Review. Adopted as amended.

This resolution asked that MSMS urge Medicaid to revise its threshold for hospital Medicaid case reviews.

MSMS has made Medicaid officials aware of physician concerns with the two percent denial rate currently used as a threshold for initiating a complete hospital case review. Medicaid officials have indicated they will keep MSMS concerns in mind when renewing their utilization review contract with MPRO. The Medicaid Liaison Committee plans to review further details of the pending contract at an early 1990 meeting.

105-89A Title: Michigan Peer Review Organization (MPRO) Sanctions. Substitute Resolution (in lieu of 37-89A and 105-89A). Adopted. See Resolution 37-89A.

106-89A Title: Expert Witnesses. Adopted as amended.

This resolution directed MSMS to seek legislation requiring expert witnesses to be in active practice in the same field of the defendant at the time of the alleged malpractice.

Legislation is pending to amend the 1986 tort reforms by changing several provisions of concern to MSMS. Sponsors of the legislation have indicated their interest in revising the expert witness requirements as part of this legislation. At this time, however, tort reform legislation is not likely to move in the Legislature due to the broad interest in pursuing alternatives to tort.

107-89A Title: Professional Liability Coverage for Medicaid Obstetrical Care. Adopted as amended.

This resolution is one of several addressing concerns about liability and care of Medicaid patients, and specifically asks that MSMS explore means of having the state cover liability expenses for obstetrical care of Medicaid patients.

As discussed in the report on Resolution 21-89A, the MSMS Medicaid Liaison Committee is currently working with Medicaid officials to explore the possibilities of implementing a State Legal Expense Fund, similar to that currently operating in Missouri.

108-89A Title: Reproductive Health Education in Schools. Substitute Resolution (in lieu of 51-89A, 108-89A, 121-89A and 125-89A). Adopted. See Resolution 51-89A.

109-89A Title: Selection of Expert Witness. Disapproved.

110-89A Title: Information Program on Chemical Materials, Radioactive Materials, and Toxic Substances. Adopted as amended.

This resolution called for MSMS to inform members about the public health effects of chemicals, radioactive materials and toxic substances.

A *Michigan Medicine* special report was developed in 1989 to provide information on a variety of environmental health topics; a second magazine feature on environmental health will appear in June. The Liaison Committee with MDPH this year sponsored a course at the MSMS Annual Scientific Meeting, covering issues related to toxic substances and radioactive materials. The 1990 Annual Scientific Meeting will feature a plenary session on environmental health. MSMS also is participating in the MDPH Council on Environmental Quality, which will be monitoring environmental impacts on public health.

111-89A Title: Schedule II Prescription Drugs. Substitute Resolution (in lieu of 111-89A and 112-89A). Referred to the Board for study.

This resolution asked that the MSMS Board of Directors evaluate the drugs currently included in the triplicate prescription requirement and take appropriate action in the study of other drugs which should be included.

The Committee on Medical Licensure and Discipline examined this resolution and concluded that it is premature, at this time, to extend the triplicate prescription requirement to additional drugs. The Committee will continue to monitor this issue and will report to the House of Delegates in 1991.

112-89A Title: Benzodiazepines to be Written on Triplicate Prescriptions. Substitute Resolution (in lieu of 111-89A and 112-89A). Referred to the Board for study. See Resolution 111-89A.

113-89A Title: Requirement for the Peer Review Organization (PRO) Physician Reviewer to be a Specialist in the Field Represented by the Attending or Consulting Physician Affected by a Denial for Substandard Quality Care at all Stages of Case Review. Adopted as amended.

This resolution asked the Michigan Delegation to the AMA to request the AMA to seek a requirement from the Health Care Finance Administration (HCFA) that the PRO specialty-specific physician reviewers of alleged substandard quality of care cases be a specialist in the field represented by the affected attending or consulting physician responsible for the delivery of care in question.

The Michigan Delegation to the AMA did not forward this resolution because it is aware of the many efforts of the AMA to persuade HCFA of the need for physician reviewers who are geographically diverse and able to offer a reasonable evaluation of patterns of practice in a variety of settings. The AMA Council on Medical Service issues reports on

- "Peer Review Organization Program Status" at both the Annual and Interim Meetings of the House of Delegates which, among other issues, discuss negotiations on the need for physician reviewers and consultants reflective of both urban and rural physicians of all specialties as well as large and small hospital environments.
- 114-89A **Title: Identification of Ancillary Medical Care Professionals to Assure Quality Performance.** Adopted as amended.
- This resolution called for MSMS Liaison Committee with MPRO to coordinate with appropriate state societies of ancillary medical care professionals a program to identify each practicing professional.
- The MSMS Liaison Committee with MPRO has investigated the possibility of creating a program of this nature with representatives of various ancillary medical care professionals and with representatives of the Michigan Peer Review Organization of Michigan. Although all organizations are interested in this project, the work design and computer software do not exist at this time.
- 115-89A **Title: Specialty Societies to be Responsible for the Creation of Written Screen Criteria to be Used by all PRO Reviewers.** Adopted as amended.
- This resolution called upon the Liaison Committee with the Michigan Peer Review Organization and Specialty Societies to develop screen criteria to be used by all MPRO reviewers.
- The MSMS Liaison Committee with MPRO has coordinated with approximately ten specialty societies to establish or modify review criteria for the Pre-Admission and Pre-Screening Procedures (PAR Procedures). The first cycle of work on this resolution is completed.
- 116-89A **Title: Peer Review Organization (PRO) Quality Denial Letters.** Substitute Resolution (in lieu of 48-89A, 60-89A and 116-89A). Adopted. See Resolution 48-89A.
- 117-89A **Title: Firearms Control.** Substitute Resolution (in lieu of 100-89A, 117-89A and 141-89A). Adopted as amended. See Resolution 100-89A.
- 118-89A **Title: Triplicate Prescription Forms for Hospital Use.** Disapproved.
- 119-89A **Title: Physician's Recovery Network.** Substitute Resolution (in lieu of 45-89A, 50- 89A, 56-89A and 119-89A). Adopted. See Resolution 45-89A.
- 120-89A **Title: Repeat Michigan Peer Review Organization (MPRO) Reviews of the Same Medical Case.** Adopted as amended.
- This resolution asked the Michigan Delegation to the AMA to request the AMA to resolve differences that may occur in serial reviews performed by MPRO and the SuperPRO.
- The Michigan Delegation to the AMA did not forward this resolution because it was unsure of the intended role for the AMA. AMA efforts on behalf of physicians and patients dealing with peer review organizations are well documented through regular reports from the AMA Council on Medical Service to the AMA House of Delegates. Michigan physicians are made aware of those reports following the Annual and Interim Meetings of the AMA through publication in *Michigan Medicine*.
- 121-89A **Title: Public School Teaching Regarding Sexually Transmitted Diseases.** Substitute Resolution (in lieu of 51-89A, 108-89A, 121- 89A and 125-89A). Adopted. See Resolution 51-89A.
- 122-89A **Title: Public Education on Hazards of Tanning Parlors.** Amended and referred to the Board.
- This resolution asked that MSMS support an educational campaign to secure appropriate regulations for tanning parlor facilities.
- At the request of MSMS, Senate Bill 661 was introduced by Senator Jack Faxon, that would regulate tanning parlor facilities in Michigan. MSMS is currently working with Senator William Sederburg, Chairman, Senate Health Policy Committee, in an effort to schedule a hearing on SB 661. MSMS expects hearings to begin on SB 661 in May, 1990.
- 123-89A **Title: Michigan Peer Review Organization (MPRO) Sanctions.** Sub-
- stitute Resolution (in lieu of 41-89A and 123-89A). Adopted. See Resolution 41-89A.
- 124-89A **Title: Peer Review Organization Time Limit.** Adopted as amended.
- This resolution asked the Michigan Delegation to the AMA to address the problem of delayed review by Peer Review Organizations (PRO) and establish a reasonable time limit from date of discharge wherein the review process must be accomplished.
- The Michigan Delegation to the AMA did not forward a resolution on this issue because it was aware that timeliness of reviews has been and continues to be the subject of AMA efforts as evidences through regular reports on "Peer Review Organization Program Status" from the AMA Council on Medical Service.
- 125-89A **Title: Reproductive Health Education in Schools.** Substitute Resolution (in lieu of 51-89A, 108-89A, 121-89A and 125-89A). Adopted. See Resolution 51-89A.
- 126-89A **Title: Health Services for Teens.** Substitute Resolution (in lieu of 12-89A, 85- 89A and 126-89A). Adopted. See Resolution 12-89A.
- 127-89A **Title: Medical Waste.** Adopted.
- This resolution encourages MSMS to cooperate with state officials in seeking safe methods of medical waste disposal, and directs MSMS to support reasonable regulation of medical waste disposal practices.
- MSMS has worked with the Michigan Department of Public Health to inform members about MDPH rules regulating the disposal of medical wastes. MSMS supported state action in developing the rules and subsequent legislation as an alternative to Michigan participation in the cumbersome and complex federal medical waste tracking legislation. Legislation incorporating the MDPH rules into statute has been enacted, MSMS is now working with MDPH on implementation of the legislation and strategies to inform physicians about the rules.
- 128-89A **Title: Non-Biodegradable Trash.** Adopted as amended.
- This resolution called upon MSMS to use biodegradable products at its meetings; to encourage members to use biodegradable products in their offices and in hospitals; and to seek information regarding alternative waste disposal methods.
- MSMS has collected information from two hospitals in Michigan which have discontinued use of non-biodegradable products in their food service areas and will disseminate information on their programs via *Medigram* and *Michigan Medicine*. Information regarding recycling programs throughout the state is also being collected for publication in future MSMS publications.
- 129-89A **Title: Look and Sound of Medications.** Adopted as amended.
- This resolution asked the Michigan Delegation to the AMA to ask the AMA to work with the FDA to write regulations which would encourage drug manufacturers to make medications uniquely identifiable by name and appearance.
- The Michigan Delegation to the AMA did not forward this resolution to the AMA because the problem of "look-a-like" drugs has previously been identified and incorporated through the AMA-sponsored national Steering Committee on Prescription Drug Abuse that brings together more than 20 national organizations and government agencies in a mutual effort to devise and implement cooperative approaches to solve the problems or misuse and abuse of prescription drugs. The AMA House of Delegates most recently discussed the problem when it adopted Substitute Resolution 93 (A-89) which, among other things, reaffirms AMA disapproval of product-specific marketing of prescription drugs because of the confusion it can create for patients.
- At the June Annual Meeting, the House also adopted Substitute Resolution 90 (A-89) directs the AMA seek to have implemented the actions called for in Resolution 44 (A-87) which calls for the AMA to "maintain a close liaison with the Food and Drug Administration (FDA) as the FDA readdresses the imprint coding issue with the explicit aim of assuring that any resultant action to modify existing systems be of benefit to patients and physicians."

- 130-89A **Title: Mediation: Education of Physicians and Collection of Data.** Adopted as amended.

This resolution asked that MSMS work with component medical societies to establish programs to enhance the knowledge of the physician mediator and that MSMS collect data on mediation.

The 1990 Michigan State Medical Society/Michigan Physicians Mutual Liability Company Risk Management Seminars, to be held throughout the state beginning in March, will feature a presentation on how physicians can serve more effectively as mediators.

In addition, both Michigan Physicians Mutual Liability Company (MPMLC) and Physicians Insurance Company of Michigan (PICOM) have agreed to supply MSMS with data on mediation.

- 131-89A **Title: Arbitration: Education of Physicians and Collection of Data.** No action.

- 132-89A **Title: Generic Labeling.** Referred to the Board for study.

This resolution asked that MSMS request the appropriate state agencies to require the indication of both brand and generic names on the label of dispensed non-combination medications and that MSMS ask the appropriate state agencies to require the indication of dispensed brand name and most common brand name on all dispensed combination medications.

MSMS is working with the Michigan Board of Pharmacy, the Michigan Department of Public Health, and the Department of Licensing and Regulation to study the issues raised by this resolution.

MSMS has sent a letter to the Michigan Department of Licensing and Regulation and the Michigan Board of Pharmacy requesting that they examine the current policies related to this issue. MSMS is still awaiting their response.

- 133-89A **Title: Attached Passive Restraints in Rental Cars.** Adopted.

This resolution requested that MSMS urge the state legislature, the Michigan Secretary of State, and the appropriate state agencies to pass laws or institute rules that would require rental agencies to ensure that all vehicles with passive belt systems are delivered to renters with passive restraints attached and in good working condition with directions for their use.

MSMS has worked with the Michigan Coalition for Safety Belt Use in an effort to seek legislation to require rental agencies to ensure that vehicles have passive belt systems. It appears politically unfeasible to obtain passage of this type of legislation at this time.

One section of this resolution asked the Michigan Delegation to the AMA to ask the AMA to seek and support appropriate Federal legislation or rules that would require rental agencies to ensure that all vehicles with passive belt systems are delivered to renters with passive restraints attached and in working condition with directions as to their use.

AMA Resolution 71 (I-89) was introduced by the Michigan Delegation at the December Interim Meeting of the AMA. The House accepted an amendment to the title and adopted a Substitute Resolution 71 as amended to read:

Operational and Accessible Safety Belts in Rental Cars and Taxicabs.

RESOLVED, That the American Medical Association develop model legislation that would require rental agencies to ensure that all vehicles with passive belt systems are delivered to renters with passive restraints in operational condition and with directions as to their use; and be it further

RESOLVED, That the AMA develop model legislation that would require taxicab companies or drivers to ensure that their vehicles have operational and readily accessible safety belts for passengers.

- 134-89A **Title: Diabetes and Pregnancy.** Adopted.

This resolution supported the MSMS Board of Directors action in disapproving guidelines developed by the Michigan Department of Public Health related to diabetes and pregnancy, and called upon MSMS to work with the Department in assuring sufficient physician input into

development of future medical guidelines.

MSMS has held several meetings with MDPH leadership to discuss physician concerns with medical guidelines developed by a state agency. MSMS is now represented on all MDPH Committees developing similar guidelines. In March, the Board of Directors adopted a policy regarding MSMS endorsement of guidelines developed by state agencies, stating that MSMS does not endorse any recommendations, protocols or guidelines prescribing standards of medical practice, unless developed by a national medical specialty organization or by MSMS

- 135-89A **Title: Pre-Participation Evaluation for School Age Athletics.** Adopted as amended.

This resolution directed MSMS to encourage the State Board of Education to require that only physicians (MDs/DOs) perform or coordinate pre-participation evaluations for the young athlete and that MSMS encourage physicians to participate in these evaluations at a reasonable cost and in a timely fashion.

MSMS has sent a letter to the State Board of Education urging that only physicians (MSs/DOs) be allowed to perform or coordinate pre-participation evaluations for young athletes. MSMS will follow this with an article in *Michigan Medicine* encouraging to provide the evaluations in their communities.

- 136-89A **Title: Improvement of Motorcycle Headlighting for Highway Safety.** Adopted as amended.

This resolution asked MSMS to seek regulations that would provide that in order to obtain a license for travel on any Michigan highway, motorcycles must be equipped with two standard sealed beam headlights, set far enough apart to be discernible as two distinct lights, that can be switched from high to low beam.

MSMS has written to the Michigan Secretary of State urging their consideration in seeking legislation that would require standard headlights for motorcycles. In responding to this request, the Secretary of State's office indicated that further study of this issue is needed prior to pursuing legislation and/or regulations. MSMS will continue to work with the Secretary of States office to implement this resolution.

- 137-89A **Title: Alternative to Tort System for Malpractice.** Disapproved.

- 138-89A **Title: Reporting to Licensure Board.** Amended and referred to the Board.

This resolution asked MSMS to seek amendments to Michigan laws requiring investigation of physicians by state licensure boards, so the investigation would occur only for physicians according to specific criteria established by the Michigan Board of Medicine.

This resolution was reviewed by the Committee on Medical Licensure and Discipline. The Committee approved a report that supports the development of specific criteria for investigations of physicians. The Committee will continue to work to encourage the Department of Licensing and Regulation to establish specific criteria for investigations of physicians.

- 139-89A **Title: Michigan Seat Belt Usage Law.** Adopted as amended.

This resolution asked MSMS to seek legislation to remove the provision in current law which limits comparative negligence for not using a seat belt to five percent and also requested that MSMS support and seek legislation to require front seat passengers in vehicles which have passive restraints which can be detached to have the passive restraints properly adjusted and in good working condition.

MSMS has written to the Michigan Secretary of State urging their consideration in seeking legislation that would remove the provision in current law which limits comparative negligence for not wearing a seat belt to five percent. MSMS is also working with the Michigan Coalition for Safety Belt use to seek this legislation. MSMS anticipates difficulty in gaining support for this issue during this legislative year.

- 140-89A **Title: Reduction of Michigan State Medical Society Dues.** Disapproved.

- 141-89A **Title: Make Illegal the Sale and Ownership of Semi and Full Automatic Assault Weapons.** Substitution Resolution (in lieu of 100-89A,

- 117-89A and 141-89A). Adopted as amended. See Resolution 100-89A.
- 42-89A **Title: Medicaid Review Criteria.** Adopted.
- This resolution asked MSMS to request that the Medicaid program make available its criteria for authorizing prior authorization for hospital admissions.
- Discussion of this resolution led the MSMS Medicaid Liaison Committee and Medicaid officials to the conclusion that several elements of the Medicaid policy for prior authorization need revision. The Committee plans a review of the existing policy and will work with Medicaid on appropriate revisions including publication of the criteria.
- 43-89A **Title: Improving the Medicaid Program.** Substitute Resolution (in lieu of 95-89A and 143-89A). Adopted. See Resolution 95-89A.
- 44-89A **Title: Utilization of Discarded Medical Materials.** Adopted as amended.
- This resolution asked MSMS to explore establishing a relationship with an international organization to channel reusable medical materials to countries in need.
- MSMS has become aware of several organizations in need of medical materials, and of several MSMS members who are active in efforts to provide needed supplies to areas in need. MSMS has and will continue to publicize these efforts and the needs of specific organizations to its members through publications and conferences.
- 45-89A **Title: National Health Service Corporation Program for Michigan.** Referred to the Board.
- This resolution called for MSMS/HMSS to evaluate the possibility of developing a Health Service Corporation program in Michigan.
- The MSMS/Hospital Medical Staff Governing Council submitted an action report to the MSMS Board of Directors recommending that in consideration of potential legislation the MSMS Board of Directors take no further action regarding the possibility of creating a health service corporation program in Michigan. On January 17, 1990, the MSMS Board of Directors approved the recommendation, amended to read: "That the Board of Directors recommended to the House of Delegates that no further action be taken on this resolution at this time."
- 46-89A **Title: Financial Aids and Loans.** Adopted as amended.
- This resolution asked the Michigan Delegation to the AMA to request the AMA to encourage the US Department of Health and Human Services to eliminate its requirement that independent students submit parental information, thereby correlating with the policy of the US Department of Education.
- AMA Resolution 149 (A-89) was introduced by the Michigan Delegation at the June Annual Meeting of the AMA. The House considered it together with Resolution 250, amended the title and adopted the following Substitute Resolution 250 in lieu of Resolutions 149 and 250:
- Financial Information Requirements for Independent Medical Students.*
- RESOLVED, That the American Medical Association urge the Department of Health and Human Services to abolish its requirement that independent students submit parental financial information when applying for financial assistance, consistent with the current policy of the Department of Education.
- 47-89A **Title: National Board Medical Examinations Part I and II.** Disapproved.
- 48-89A **Title: Requirements for Licensure by Endorsement for Graduates of Foreign Medical Schools (GFMS).** Adopted as amended.
- This resolution asked MSMS to work with the legislature to enact the AMA model bill which provides that graduates of foreign medical schools and graduates of US medical schools must meet the same requirements for licensure by endorsement.
- MSMS is currently working with Representative David Gubow (D-Huntington Woods) to introduce legislation that would satisfy this resolution.
- MSMS expects this legislation to be introduced when the legislature returns from its Easter break.
- 149-89A **Title: Commendation for the Michigan State Legislature.** Substitute Resolution (in lieu of 67-89A and 149-89A). Adopted. See Resolution 67-89A.
- 150-89A **Title: Mandatory AIDS Testing for Marriage Applicants and all Hospital Admissions.** Late Resolution not accepted for introduction.
- 151-89A **Title: Coverage for Malpractice to be Contingent on Membership in MSMS and County Medical Societies.** Late Resolution not accepted for introduction.
- 152-89A **Title: Salary Executive Vice President AMA.** Late Resolution not accepted for introduction.
- 153-89A **Title: Amend House Bill 4157.** Adopted as amended.
- This resolution asked that MSMS work to amend House Bill 4157 in setting guidelines to protect those who in good faith have interpreted the alleged abuse different from the courts and/or other parties.
- The Committee on State Legislation and Regulations has closely reviewed HB 4157 and has found that the current language contained in HB 4157 does not impact on abuse reporting. The Committee will continue to monitor any further action on HB 4157.
- 154-89A **Title: Stop Michigan BCBSM from Joining the Plaintiff in Medical Liability Cases.** Referred to the Board for action.
- This resolution asked that MSMS discover the number of cases BCBSM has joined the plaintiff as a third party against physicians and to stop BCBSM from engaging in this activity.
- BCBSM responded to MSMS through correspondence on this issue on May 11, 1989. MSMS has reviewed this issue and the BCBSM response with our legal Counsel. We have accepted the BCBSM correspondence as satisfactory and the BCBSM action as appropriate.
- The MSMS/BCBSM Liaison Committee reviewed this resolution at their meeting on January 10, 1990.
- The resolution was discussed by Committee members where it was reported that MSMS Legal Counsel had reviewed this issue and indicated there is no legal problem. The Committee also reviewed BCBSM's Litigation Department's letter dated May 11, 1989, regarding this resolution. The Committee accepted the BCBSM Litigation Department's explanation of their activity as a silent party in conjunction with any proceedings which are directed towards settlement. The Committee also recognized the 1986 tort reform law which permits an injured plaintiff to recover from the defendant provable damages including reimbursement. The MSMS/BCBSM Liaison Committee determined that in consideration of the legal information presented on this matter, the MSMS Board of Directors take no further action regarding attempt to stop BCBSM from joining the plaintiff in such determinations.



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- Heals duodenal ulcer
rapidly and effectively^{4,5}
- Dosage for adults with active
duodenal ulcer is 300 mg once nightly
(150 mg b.i.d. is also available)

References

1. *USP DI Update*, September/October 1988, p 120.
2. *Br J Clin Pharmacol* 1985;20:710-713.
3. Data on file, Lilly Research Laboratories.
4. *Scand J Gastroenterol* 1987;22(suppl 136):61-70.
5. *Am J Gastroenterol* 1989;84:769-774.

AXID[®] nizatidine capsules

Brief Summary. Consult the package literature for complete information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to eight weeks of treatment. Most patients heal within four weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than one year are not known.

Contraindication: Known hypersensitivity to the drug. Use with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given

an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatoceellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported. **Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H₂-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

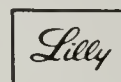
Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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Additional information available to the profession on request.



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Report of the Michigan Delegation to the American Medical Association — Robert D. Burton, MD, Chairman

The 24-member Michigan Delegation to the AMA has just concluded another active and productive year. Highlights were the AMA Annual Meeting June 18-22, 1989, in Chicago, and the AMA Interim Meeting December 3-6, 1989, in Honolulu, Hawaii.

At the June meeting, delegates were pleased with the reelection of former Delegation Chairman, Frank B. Walker, MD, to a full three-year term on the MSMS Board of Trustees. Doctor Walker had been elected a year earlier to fill a one-year unexpired term on the Board. Other Michigan Delegation members who were successful in their campaigns for AMA office included Donald K. Crandall, MD, former chairman, AMA Council on Medical Service, who won reelection to the Council; and A. Bradley Eisenbrey, MD, who won election to the resident physician spot on the Council on Scientific Affairs.

We presented three outstanding candidates to the AMA, and our simple formula worked. Praise is due the Michigan AMA family members who worked hard and long to accomplish their candidates' election.

Major events of the AMA House of Delegates annual meeting were announcements of national campaigns 1) to "strengthen the US health care system and to provide remedies for correcting present shortcomings," and 2) to avert enactment of proposed Medicare expenditure targets (ETs). The AMA Board authorized spending up to \$2.5 million on the first campaign, for which the AMA already had developed three specific legislative programs. They called for reforming and expanding the Medicaid program, for mandated employer-provided health insurance, and for reform of the Medicare program.

The Michigan Delegation introduced 10 resolutions at the June meeting. Five of the 10 were approved at least in substitute. They were:

#144 — Encourage more involvement of graduates of foreign medical schools in AMA policy-making — Approved.

#150 — Support national beverage container reuse and recycling program — Approved.

#145 — Work to change Medicare voucher terminology from "reasonable charge" to "covered amount" — Adopted as amended.

#147 — Seek to restrict promotion of durable medical goods directly to the public — Substitute adopted.

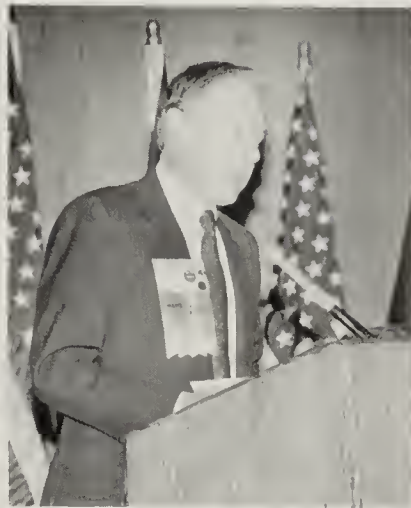
#149 — Work to eliminate requirement that independent students provide parents' information when applying for financial aid — Substitute adopted.

Three Michigan resolutions were referred to the AMA Board of Trustees. They seek AMA efforts to 1) eliminate religious exemptions allowing parents to withhold proper medical attention from children, 2) restrict anabolic steroid use, and 3) discourage use of infant walkers. The remaining two Michigan resolutions — to outlaw use of assault rifles, and to create an AMA membership lapel pin — were defeated.

The Michigan Delegation introduced seven resolutions at the Interim meeting of the AMA. Michigan physicians' strength on the national scene is well known. Our delegates receive respect, and even rapt attention, when they speak on the issues. Following are the voting results:

#69 — Opposing mandatory, centralized, postgraduate medical education, and reaffirming AMA support of a pluralized system — Adopted.

#70 — The AMA to support legislation to protect graduates of foreign medical schools from discrimination in such areas as licensure, promotions, privileges, reimbursement, financial aid, and academic appointments — Referred to Board. The AMA Board has since referred the issue to the Council on Medical Education, which held hearings at which Michigan's Busharat Ahmad, MD, and Krishna Sawhney, MD, testified. The Council will report back to the AMA House in June.



#68 — Calling for changes in HCFA's Quality Intervention Plan so that quality indicators would be made only by physicians and physicians notified when each level of alleged mismanagement is determined, and so that the term "significant adverse effect" is more narrowly defined — Referred to the Board, for report back at the 1990 Annual Meeting.

The AMA delegates adopted a substitute in lieu of the Michigan resolution to require working passive seat belt systems in rental vehicles. It calls for those systems to be in working order and to come with instructions for use. The AMA already has a policy calling for such systems in rental vehicles.

Delegates also adopted a report in lieu of a Michigan resolution calling for the AMA to work with HCFA to reduce demands for review of medical records and charts.

The Michigan AMA family celebrated the election of University of Michigan graduate Laurie McKeown, MD, as chairperson-elect of the AMA Resident Physician Section. The Michigan Young Physicians Section successfully won state and then AMA approval of a resolution calling for the AMA to work for lower blood alcohol levels as per se illegal for driving.

Members of the Michigan Delegation to the AMA are:

Delegates: Robert D. Allaben, MD, Detroit; Billy B. Baumann, MD, Pontiac; Donald K. Crandall, MD, Muskegon; Carl A. Gagliardi, MD, Dearborn; Richard H. Gascoigne, MD, Adrian; Gerald H. Mandell, MD, Detroit; Robert E. Paxton, MD, Fremont; Thomas C. Payne, MD, Lansing; Richard L. Rapport, MD, Flint; Karen Vanderwall, Wayne State University, and Louis R. Zako, MD, Dearborn Heights.

Alternate Delegates (in order of seniority): Busharat Ahmad, MD, Marquette; Robert W. Black, MD, Detroit; R. Jack Chase, MD, Grand Rapids; Rhoda M. Powsner, MD, Ann Arbor; Susan H. Adelman, MD, Southfield; Cathy O. Blight, MD, Flint; B. David Wilson, MD, Kalamazoo; Peter A. Duhamel, MD, Rochester; Marguerite Shearer, MD, Dexter; Willard S. Stawski, MD, Grand Rapids; Charles C. Vincent, MD, Detroit; and Brian F. Jewell, MD, Detroit.

Report of the Michigan State Medical Society Auxiliary — Suzanne H. Pederson, President

It seems impossible it is the end of my year as president of the Michigan State Medical Society Auxiliary.

One of my great pleasures has been visiting the counties. We are a diverse group, each county has its own traditions. The spirit of togetherness and understanding draws each group together.

I am very proud of the word of each committee chairman and each committee member. The AMA Education and Research Fund Committee has raised \$29,000, most of which remains in the State of Michigan to benefit its medical schools.

The Health Projects Committee, at the request of MSMS, assisted with a second printing of our Detroit Pistons "Say No to Drugs" poster. Once again, as it was when we initiated the project, a very popular item with sellout capacity. The committee also compiled packets of information. The Physician Information Packet details how primary care physicians can easily incorporate a strong alcohol and drug abuse prevention message into their everyday practice without taking physician time.

The Legislative Committee has been working in conjunction with the Government Affairs Department of MSMS to coordinate legislative efforts. They also have supervised, along with an ad hoc committee, the distribution of the liability video, "Medicine in Jeopardy."

We have held the line with our membership numbers with a slight increase, a rarity across the nation, due to innovative ideas implemented by our Membership Committee.

Our affiliation with MSMS is becoming closer all the time, mostly due to the efforts of Bill Madigan, who has been most cooperative. The meetings with MSMS leadership have been fruitful and are scheduled to continue on a timely basis. Susan Adelman, MD, will address our House of Delegates Wednesday, May 10.

It is impossible for me to adequately express the gratitude I have for the support given to me and the Auxiliary by Bob Paxton. We both realize the only way for medicine to have a stronger position in the State of Michigan is for us to unify and coordinate our efforts. Though we may sometimes disagree, we must present a united front. The present tactics of external agencies seem to be divide and conquer. Together we must "wake the sleeping giant."

The auxiliary is appreciative of the financial and moral support you give to us. I am very proud of the accomplishments of the Society and the Auxiliary.

Thank you for the friendship and consideration extended to me during my tenure as president of the Michigan State Medical Society Auxiliary.

Report of the Physician's Review Organization of Michigan, Inc. — Robert C. Prophater, Sr., MD, President

I am pleased to inform you, PROM ended the 1989 fiscal year with a profit of approximately \$29,000. PROM has met its annual obligation on its debt to MSMS as well as paying approximately \$22,000 in interest to the association. PROM is fiscally strong and plans in 1990 for expansion of its activities in order to maintain this fiscal position.

PROM's core of business continues to be case review. During 1989, 4,000 case reviews were completed for the eight insurance companies now under contract. In addition to this, the Corporation continues to look for ways to expand its base of operation. An area of significant growth in the past year has been requests from hospitals to assist with medical staff credentialing issues. We believe this area will continue to grow in the future and become an increasing part of PROM's activities.

During 1989, much of the PROM Board of Directors activities have focused in two areas. During the year, the PROM Board established a new, more extensive questionnaire for reviewers and has begun to re-credential reviewers on a three year cycle. The number of physicians willing to perform review for PROM continues to increase. The Board believes these physicians are of highest quality clinically active physicians in the state. Another area the PROM Board has focused on is behavioral medicine review. Review in this area has proven to be extremely difficult and in order to address these issues, the PROM Board has scheduled a conference on peer review in the behavioral medicine field. We believe this conference will add to the discussions currently taking place regarding whether traditional review systems can be applied to the area of behavioral medicine.

PROM currently is discussing with Michigan Physicians Mutual Liability Company (MPMLC) the possibility of assisting them in their risk management efforts. By using trained reviewers to analyze liability cases, PROM can add a clinical aspect to the current risk management efforts. Through MSMS's efforts, PROM has been discussed in regards to assisting the Board of Licensing and Regulation in analyzing physician practice patterns and qualifications. In addition, the Federal Government has made large amounts of money available for grants in the area of determining the outcome of medical care as well as addressing the issue of "re-training" physicians displaying deficiencies in their medical practice.

PROM looks forward to continuing its work in 1990. It believes it is making a significant financial contribution to MSMS as well as assisting the association in its efforts to ensure review systems are equitable and reflect the clinical realities of medicine. It is time for the Corporation to move beyond case review and begin to address other areas needing clinical perspectives. The hospital credentialing activity will grow in 1990 as more hospitals become aware of its availability.

PROM has developed a new brochure which will be sent to chiefs of staff and CEO's of hospitals and other interested individuals to introduce PROM's abilities and to explain its procedures. Additionally, we believe that in the future, PROM will be increasingly involved in the area of risk management and the analysis of physician practice patterns and qualifications.

Members of the Board include: Mary O. Anderson, MD; Robert W. Black, MD; Edwin Doehring, DO; Andrew J. Hogan, PhD; William E. Madigan; Marsha Milburn, MD; Robert C. Packer, MD; Richard L. Rapport, MD; Donald C. Smith, MD; and Floyd C. Stevens, DO.

Report of the Physician Service Group, Inc. — Billy Ben Baumann, MD, President

For the first time, Physician Service Group, Inc. (PSG) had revenues over \$1,000,000. During 1989, the PSG Board paid a dividend of \$90,000 to MSMS as the sole shareholder of the corporation. Additionally, PSG made a double payment on its debt to MSMS. Along with these monies, PSG paid approximately \$24,000 in interest. With the other services purchased from MSMS, the Corporation is providing a significant source of income to the Michigan State Medical Society.

PSG's major growth activity in 1989 was in the area of physician education programs. Over 50 educational seminars were presented with approximately 2,000 MSMS members and their employees taking advantage of these educational opportunities. The seminar program has become an extremely valuable asset to Physician Service Group and it is expected to continue to grow. Already in 1990, the seminar program has received enrollments exceeding 1988, its first year of operation.

PSG's involvement with the servicing and marketing of the MSMS group insurance programs continues to expand. During 1989, approximately \$20,000,000 was billed in insurance premiums through PSG. Our subscriber service toll-free line received 13,000 calls during the year. The MSMS health insurance programs maintained approximately the same number of contracts as the previous year. We believe

this level growth is due to the fact of a 30 percent premium increase at the beginning of 1989. The MSMS Delta Dental plan has shown continued growth in its second year.

The administration of the specialty societies continues to expand. All the groups currently under contract continue to express great satisfaction with the professional administration offered by PSG. Many groups are now sending newsletters to the members, as well as receiving additional information regarding medical issues through the communication link between MSMS and PSG.

During 1989, PSG added three additional endorsed service programs. The first of these is a group purchasing agreement with the Randolph Medical Corporation. Randolph provides disposable medical supplies to physicians and is one of the largest providers of these products in the Midwest. The second endorsed service introduced in 1989 is a pooled pension fund through the Equitable. While this is a long-term marketing effort, the Equitable reports they are very pleased with the response from the MSMS members. PSG entered into this area due to our belief the cost and administrative issues involved with pension plans will cause many physicians to seek this type arrangement. The third service introduced in 1989 was a medical equipment leasing program through Bell Atlantic TriCon, Inc. This program has proven to be very successful with many physicians in the state taking advantage of TriCon's extremely competitive rates and unique leasing features. Along with these services, PSG has also entered into an agreement with Cellular One to provide at a discount, mobile phone equipment to physicians.

Overall, PSG in 1989, has increased revenues and profitability. During the current year, we believe that PSG will play a significant role in marketing other MSMS group insurance programs. Through an agreement with the Stratton Cheeseman Agency, all the current MSMS group insurance programs, other than its health products, are being reviewed and revised. In addition to these activities, PSG has already contracted with a new specialty group, the Michigan Dermatological Society, and is having discussions with a second group. The educational programs are continuing and will be expanding from the current format of half-day and full-day sessions to two-day sessions, as well as five-day workshops on practice management. The PSG Board looks forward to continuing these efforts in the future.

Members of the Board include: Frederick W. Bryant, MD; Mark Campbell, MD; Henry Domzalski, MD; Elizabeth A. Hutchinson, MD; Mark Kolins, MD; William E. Madigan; John A. Richards; and Allen F. Turcke, MD.

Report of the Health Education Foundation — Robert E. Paxton, MD, President

The Board of Trustees met January 11, 1989; May 17, 1989; September 13, 1989; January 10, 1990. The Board meets on a quarterly basis.

The Health Education Foundation, established in 1946 by MSMS for the purpose of providing medical school loans to Michigan students, was redirected in 1986 to advance the field of health for the public good. With this direction, the Foundation has successfully broadened its scope and perspective and is viewed as the philanthropic arm of MSMS. The Health Education Foundation also administers the James D. Bruce Fund, restricted to the University of Michigan Department of Pediatrics and the Impaired Physician Loan Fund.

Interested in programs focused on health education and research, the Foundation looks for innovative funding strategies. The Trustees examine changing attitudes, ethics and values with regard to prevention, intervention and educational projects. Awarded thus far in 1990 is a grant to Western Michigan University for a conference entitled "Aging in the 1990's: Alcohol and Other Drug Abuse" and one to the Michigan Health Council for a general operating grant. Several other grant requests are under review and decisions will be made at the next HEF board meeting.

Under the direction of the Foundation's President Robert E. Paxton, MD, HEF has continued to expand its visibility and broaden its base of financial support through the formation of the Health Education Foundation Planning Committee. The committee has explored and implemented several effective means to promote a greater awareness and support of the Foundation by the MSMS members and the public. The contributions received from the MSMS Board of Directors and the membership in 1989 exceeded \$7,000 which includes a challenge gift of \$2,000. An annual report will be available later this year reviewing in detail the activities of the Foundation.

Members of the Board of Trustees include: Bruce W. Ambrose; Nancy Crandall; Henry M. Domzalski, MD; William E. Madigan; Richard J. McMurray, MD; Robert E. Paxton, MD; Arthur L. Tuuri, MD; Rev. Bertram W. Vermeulen; Richard D. Weber; Elmer E. White; Louis R. Zako, MD; Suzie Pederson; Vada Davis.

Report of the MSMS Group Insurance Trust — B. David Wilson, MD, Chairman

The MSMS Group Insurance Trust initiated several activities in 1989 to benefit the MSMS membership. The first of these was the commissioning of a major study

regarding the sponsored health insurance program. This study was done by an outside consultant and looked at both the relationship with our current Blue Cross Blue Shield (BCBS) coverage and potential alternative carriers. The report concluded, due to the particular characteristics of the MSMS insured group, at this time, it would be best to maintain the relationship with Blue Cross Blue Shield. Private carriers were only interested in the MSMS group if they could tie bar the health insurance coverage to other types of insurance products and even then the indications were the rates would be substantially higher due to the unpredictability of the cost within the MSMS group.

The second major initiative the Group Insurance Trust undertook was a survey of the MSMS membership. This survey asked questions about different types of insurance products of interest to the MSMS membership. Essentially the findings of the survey were the vast majority of the members continue to be interested in the health insurance product. Additionally, several other products were mentioned as potential insurance programs the membership would like MSMS to offer.

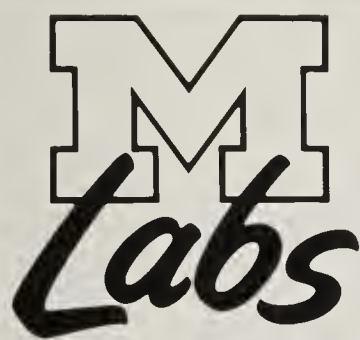
Both the survey and the consultants report found the Group Insurance Trustees must continue to improve the customer service, marketing, and the relationship it currently has with Blue Cross Blue Shield. The Trustees of the Group Insurance Trust have established an ongoing data analysis to experience of the MSMS group to establish the accuracy of the rates currently being charged. For the 1990 premium year, the MSMS group experienced no premium increase. This was due to a combination of reduced utilization and redesign of certain parts of the insurance

program. In addition to these developments in the group insurance program, the Trust was able to negotiate a unique program for the MSMS membership. In the current MSMS sponsored program, members and their employees have the ability to select a \$5 co-pay drug program independent of the level or option of coverage. The drug program is a free-standing program in which, if members want to select it, they can without it being tied to any other type of coverage or option.

The MSMS group dental program continues to show growth. This was the first association program provided by Delta Dental. It remains the only opportunity for MSMS members to purchase dental coverage without being tied to any other program or type of coverage.

The Group Insurance Trust continues to review the Blue Cross Blue Shield health insurance plan and will continue to look for other modifications in the coverage and opportunities to maintain a high quality product at a reasonable premium. The Trust will continue to work to develop other types of programs to be introduced to the MSMS membership on a group basis. Within the next year, the Trustees will be working to revamp the other insurance programs offered by MSMS. As this is completed for each product, these products will be introduced to the membership in their revised form.

Members of the Trust include: Jack L. Barry, MD; Billy Ben Baumann, MD; Henry Domzalski, MD; William E. Madigan; W. Peter McCabe, MD; Earl Moehn, MD; and Robert E. Paxton, MD.



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*We Must Dedicate Ourselves
to Our Patients and Our Profession,
says Robert E. Paxton, MD*

The poet wrote in the book of Ecclesiastes, "to everything there is a season, and a time to every purpose under heaven. A time to be born and a time to die. A time to weep and a time to laugh. A time to love and a time to hate, a time of war and a time of peace."

So it has been with your president. There has been a time for me to speak and a time to listen. A time to inspire and a time to purge. A time to be forceful and a time to be diplomatic. Finally, there is a time for leadership to change. A time to pass the torch. A time to move on. A time to reflect.

As I speak to you for the last time as your president, I want to speak from the heart. And yet, at the same time, I want to shout my message out to you. I feel akin to Plato's swan: "For the swan, when he perceives he must die, having sung all his life long, does sing more lustily than ever."

So it is with me. Tonight I would like to speak more lustily, more convincingly, more sincerely, more forcibly with more dedication, than ever before.

I would strive to leave an indelible mark — an enduring message that would be both constructive and inspiring. I contemplated for weeks what that message might be. I struggled with a thousand ideas that bubbled up like a volcano ready to erupt — ideas that I wanted to leave with you before I left office.

In wrestling with ideas, I reflected on the three goals I established when I assumed office:

- Increase membership involvement
- Promote unity
- Find realistic solutions to some of our problems, especially the malpractice crisis.

Should I talk about the degree of success we had in trying to fulfill these goals?



MSMS President Robert E. Paxton, MD, bids farewell to delegates at the 1990 MSMS House of Delegates meeting.

Should I speak on the state of the society? Spew out a laundry list of MSMS activities? What we have accomplished? How our priorities have worked out?

Should I deliver a homily on the ethics of medicine and the dilemma created in today's health care delivery?

These all left me cold and I felt that they would not portray the depth of my feeling and my concern for the health care of our patients, the well being of our profession and the security of the Michigan State Medical Society.

While I represented you at the Illinois State Medical Society House of Delegates a couple of weeks ago, I heard the outgoing president give his farewell speech. He concentrated on what he had heard from the grass roots as he traveled from one end of the state to the other.

It was then when the thought struck me as to what I really wanted to say. The presidency and my recent years of leadership have provided the opportunity for me to evaluate our profession, to have a first hand experience with healthcare delivery in Michigan, to know the bureaucrats and politicians, in fact, to be associated to some degree with the whole gamut of individuals and groups involved in health care.

Some valuable perceptions

This unique experience has allowed me to evaluate this arena from a special perspective. That perspective has furthermore given me some valuable perceptions that I want to share with you before I move on and close out this phase of my involvement — perceptions that I feel are significant challenges for you, the leadership of Michigan physicians!

First of all, as I traveled about the state, the membership made me very much aware of the importance of leadership communicating with them on issues of concern to them. We must give the grass roots a chance to be a vital part of our effort. There is no room for a centralization of power, of running the society by a few. Our very existence depends upon our contacts and our communication with the front line practicing physicians. This is the same lesson we have to learn at the AMA level.

This whole effort spells out sacrifice on the part of you, the leadership. You must dedicate the necessary time. Are you up to it? It's not too late, but time is critical — we must pull out all the stops and do it now!

A troubled perception I acquired as I traveled about trying to inspire, pleading for involvement and sacrifice — a disturbing feeling that grew on me as the year progressed — was a sense of inertia. I witnessed a lack of energy, a desperation, a polite gratitude for what the few are doing, but a defeated attitude that cried out, "don't involve me!"

Oh, there have been the notable exceptions and I genuinely thank those who have responded so enthusiastically, who have given of themselves. But on the whole, I perceived a failure of our mem-

bers to prioritize involvement in organized medicine — in politics and the political process — in issues facing medicine in general.

To you who are the leaders, I cry out, "wake up this sleeping giant!" Direct the combined forces of our influence, our expertise and most important, our patient power to bring about order in the chaos created by misguided, short-sighted antagonists — chaos that hurts the quality of medical care, limits access, and threatens our profession.

There is another perception which creates a real challenge for each of us — one that only we can resolve ourselves. It's a problem created both by forces from within and without. Have we as physicians lost our traditional altruistic attitudes? Have bureaucratic forces snatched it away from us? Has the emphasis on competition, business and entrepreneurial activity created in us a little of Donald Trumpishness and love of opulence, striving for a Taj Mahal?

Unfortunately, I have experienced some danger signs. I have seen some red warning flags. What I have perceived frightens me. Remember, the physician was always loved because of his compassionate care, expertise and concern for others above self. A good living was never resented by the public. Excesses may be the earmark of other professions and interests, but they are not characteristic of a doctor. We cry out the need to improve the doctor image! Could it not start here?

Let's move on. A real difficult challenge is created for us as we contemplate the possible method of health care delivery in the future. My perspective as president has made me aware of the possibility that in the next decade we probably will see the regionalization of health care. Within a particular region there will emerge a controlling unit — a dominating force — probably the most enterprising, tertiary hospital in the area. Satellites will be scattered throughout the region.

Physicians will, for the most part, be practicing in groups at a salary with all the fringe benefits. Cost limiting incentives will be based on the particular needs of the region — demographics determining the nature of health care.

The inherent dangers in this system are spine chilling! Physicians could tend to lose their uniqueness, their individuality, their fortitude. The big unit, whatever it might be, will satisfy them and cajole them like a huge security blanket, attempting to rob them of their creativity.

In the same mode, physicians will tend to isolate and care only about individual

specialty interests; they will not be motivated to speak out. As a result, organized medicine will be weakened and lose its clout, allowing those without particular medical expertise to freely establish policy based on economics rather than quality. Most important, we would tend to lose that all important ingredient which is the basis for quality care — a solid, constructive, caring doctor/patient relationship.

My last perception is the most troublesome and serious for me. There is an old Libyan fable that best describes it: "that once an eagle, stricken with an arrow, said when he saw the fashion of the shaft: 'With our own feathers, not by other's hands, are we now smitten'."

We give our opponents the means of our own destruction. We become our own worst enemy. I don't know if it's because of competition. I don't know if the alleged conspiracy of silence has prompted it. I don't know if it's because everyone is constantly yelling at us to clean up the profession when in fact quality has never been better and FTC regulations and legal antics make it difficult at best for us to get rid of the bad apples in our midst.

Growing negativism

But, I do know that there is a growing negative attitude of physicians toward each other. I am aware of sanctimonious, non-caring judgment of some peer reviewers. I do fail to hear physicians speaking in one voice because of specialty interest.

These are the feathers that will guide our enemy's arrow of destruction directly to our heart. And as we all suffer — as quality of care declines — we will in deaths throes utter why? Why? Why didn't we stay together? Dramatic? Rhetorical? Perhaps, but I sense this, I hear this, I read this, it is becoming obvious.

Why do defense lawyers tell me that we are unrelenting in our judgment of our peers? Why are PROs a priority concern in Michigan as well as across the US? Why do physicians tell me that as long as we have managed care there will be no unity?

Specialty societies fail to settle their differences within the house of medicine. The control of doctors is shifting from the AMA to Congress. Newspaper headlines almost triumphantly declare that the AMA is losing its effectiveness because of special interests and specialty societies weakening it from within.

The AMA works for all physicians in physicians payment reform. It offers a comprehensive plan on health care delivery and resolution of the access problem.

It dedicates itself to the health care of the American public and the promotion of the medical profession. Yet as it speaks for all of us, many specialties go their own way and send mixed signals that weaken our cause.

Am I discouraged? Am I distressed? Do I feel defeated? No, absolutely not. When I spoke to the membership this past year, I exhorted them to stay upbeat. We have survived many crises in the history of medicine and indeed, we will survive the radical changes facing us. We will overcome the threats hurled at us from all directions.

I cannot help but think of President John Kennedy's challenge. Let me paraphrase it for our purpose. For to those to whom much is given, much is required. And when at some future date the high court of history sets in judgment on each of us, recording whether in our brief span of service we fulfilled our responsibilities to mankind and our profession, our success or failure will be measured by the answer to four questions.

- First, were we truly physicians of courage?
- Second, were we truly physicians of judgment?
- Third, were we truly physicians of integrity?
- Finally, were we truly physicians of dedication?

Physicians have always had the heart of a lion, courageously making life and death decisions. I see no lack of courage.

We are trained to make judgment calls. That is what we do best. I see no lack of judgment.



"I have no words to express my thanks to the one most responsible for any success that I might have had," MSMS President Paxton said of his wife, Georgia Mae, right.

Reimbursement mechanisms, regulation and possibly managed care have tested our integrity — but I truly trust the physicians.

What bothers me is what our answer will be to the question, are we truly physicians of dedication? Our dedication must be directed both toward the welfare of our patients and toward our profession. The temptation is there to go for a 40-hours per week, well-paying job, performing our services in a technically satisfying manner — forgetting the human, compassionate, caring aspect that has made our profession great in the past. Forgetting the responsibility we have to future generations of doctors to carry on in our traditional greatness. Forgetting about self-sacrifice in order to serve our patients and our profession better.

But, as I have repeatedly said before — we are strong — we are respected — we have a just cause. MSMS staff is superb, leadership dedicated, grass root involvement increasing all the time. I have confidence in my colleagues. I remain optimistic about the future. I have complete faith in you — the leadership of MSMS! We shall respond!

Remember, the involvement and dedication you set as an example is contagious and will spread. As you become more enthusiastic, more optimistic — so will our membership become more enthusiastic and optimistic. Carlyle put it so well: "All work is as seed sown — they grow and spread and sew themselves anew!"

Presidential reflections

Before I close this chapter, I would like to shift gears and share some thoughts about the presidency with you. There have been times, good times when everything seemed to succeed. But I didn't let it alarm me, I knew it would pass.

I measured my progress if any week's problems were different from the week before!

At times this job was frustrating. So often I wanted things to move more rapidly — many times I couldn't understand why there wasn't more action. But I guess I stand in good company. It's been said that at one time President Hoover complained to his predecessor Calvin Coolidge, at the onset of the great depression, that his recovery plan was making little impact on the nation. His critics were getting unduly angry with him.

The former president tried to soothe Hoover by reminding him that you can't expect to see any calves running in the fields the day after you put the bulls to the cows! The unhappy president responded, "No, but I could at least expect to see contented cows!"

I would remind the Society that our past presidents do have a great deal to offer. Call on us when we can be of help. The ninety-year-old Chief Justice Oliver Wendell Holmes said, "The riders in a horse race do not stop short when they reach the goal. There is a little finishing canter before coming to a standstill." We say to ourselves, the "work is done." But just as we say that, the answer comes, "the race is over, but the work is never done while the power to work remains."

Throughout the past year, I concluded all my speeches to our membership with the same plea. Practice quality care, emphasize compassion and caring and we will emerge greater than ever before. Your response and your involvement are imperative to our success and I urge you to stay upbeat. Above all, remain united even though it will hurt a little on occasion. Be proud of your profession for it is the greatest there is! Thank you.



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*We Must Support
the Interests of Our Patients,
says Susan Hershberg Adelman, MD*



President-Elect Susan H. Adelman, MD, discusses her goals for the coming year as MSMS president.

"It was the best of times. It was the worst of times." This begins *A Tale of Two Cities*. Dickens was talking about the French Revolution, but the quote also fits the beginning of the American Health Care Revolution. The 1990s unquestionably will be a decade of the greatest change that any of us in medicine have ever seen. If fact, many of us are still reeling from the impact of the 1980s.

A Tale of Two Cities ends: "It is a far, far better thing that I do than I have ever done. It is a far, far better world that I go to than I have ever known." Then the hero goes off to the guillotine.

There may be some lessons here, but I hope we do not have to lose our heads to learn them. Some of us in this room are not sure American medicine is going to become far, far better in the next decade. We also are afraid we may not even come close to creating a far better world. We just hope we do not mess up the world. This means we have our job cut out for us, and we do not mean it is to oppose change, but to create a world in which we and our patients will wish to live in the next millennium.

The pressure to change our medical system is building up almost logarithmically today in the US, because business, labor, government and the public all think change will be to their advantage. We need to make sure all the constituencies for change understand which of their proposals will help them in the long run and which will not. Those which only help special interest groups, even if they are our own, we must expose and oppose. This means we must learn and then teach the public the long-term effects of the many short-cuts payers urge us to take in order to save them money. If these mean cut-

rate medicine, we must make sure our patients understand they will be short-changed in the end. If these mean equivalent care, even if it is at less profit to ourselves, we must take them into serious consideration. Certainly we should support any changes which will solve real problems for our patients, not just for those who pay the bills. Most important of all, where our own interests conflict with those of our patients, we must support the interests of our patients. The measure of our wisdom may be our success in trying to reconcile as many of these differences as possible. When this appears to be impossible, then we will be tested.

The choice is ours

If we act like a trade association or a guild, looking out primarily for our own interests, we will become a trade not a profession. If we put ourselves first, as the Ontario physicians did when they went on strike for the right to balance bill, public reaction will be predictably unfriendly. Inherent in the notion of a profession is that out of respect, members of a profession are accorded privileges. If we lose this respect, we will lose the right to regulate ourselves, to control the manner in which we deliver medical care, and to establish our own professional standards. The choice is ours.

Leadership confers obligation. I believe the first obligation that goes with leadership in the medical profession is to identify membership demands which are self-indulgent, even if they are cloaked in concern for the patient, and to differentiate these from legitimate demands to preserve our ability to give patient care. Next, we must differentiate between unmet medical needs of the public and demands they may make

which simply take advantage of our goodwill and good intentions. If we could sort this out, we would be able to make the choices we need to make for the year 2000.

I believe we must define our mission the same way the public does. This means we must serve our patients, their needs, priorities, and budgets. We can try to make them more judicious in their requests for medical treatments, but we cannot change their priorities, nor can we make them richer.

If the public does not want to pay medical bills from their own pockets, we can explain clearly how this choice may affect their medical care, but we cannot pretend we do not hear them. On the other hand, if this will cause our medical superstructure to disintegrate, it is our obligation to explain why. Then they may decide this is not what they want.

If we have proposals for changing our medical system, they should really promote the interests of our patients, not just of ourselves. If we lie, the public will never forget. Will universal health insurance help our patients more or hurt them more? This depends first on whether we are talking about a national system, or a state-wide system. It depends on whether we are talking about the Canadian system, the German system, the French system, the British system, or a purely American,

homegrown system. How will this affect our office care, our hospital care, and our ability to deliver progressively more advanced, high-tech, medical services? What will the long-term effects be on our medical institutions? Will we solve the problem of 37 million uninsured Americans? Or are there only 31.5 million uninsured? Are 80 percent of these either fully or partially employed? Even a better question, are 20 percent or more uninsured by choice, because they are willing to play the lottery with their health? Should we transform our whole health care system to serve patients who may have these priorities? Or is *any* number of uninsured a national disgrace, and does it justify making major changes in our health care system? Or do the changes that we may make to cover the uninsured only *masquerade* as benefits for these patients, while they actually serve to assure us payment for their care? Will a major change in our health care system serve the interests of those who now can buy the very best care? Under any of the proposed new systems will these people no longer be *able* to buy the same quality of care that they can buy today? Is this going to happen primarily to the very persons who are pushing the hardest today for a national health care system? If so, much as we might like the irony of it all, it may be our obligation to tell them.

Patient education a major goal

One of the things I hope to accomplish in the coming year is to produce a patient information brochure which does two things: One, it provides objective questions for patients to ask about the benefits actually offered by HMOs and other managed care programs. This should help protect patients as they choose between plans. Second, this should bring home to them what reduced care they may have to accept when they sign up for any health care plan, other than traditional coverage. If patients are going to be offended by surprising limitations in their coverage, they should know that the limitations are being imposed by the insurer, or the program, not by their doctor.

In the area of professional liability, *we* are the ones pushing for change. If we want allies in our push for reform of the tort system, we have to show our patients and the major purchasers of health care how the changes we may propose would be *more* to their benefit and less expensive than the present system. The public feels that the tort system protects them,

and it may assume that an administrative system or a no-fault system does not.

Still, the public wants fair awards, prompt awards, more of their awards for themselves, less to go to lawyers, and high awards. All of this should mean that they would *support* an administrative system or a no-fault system *unless* they were counting on a big win in a jury trial. This means there is a potential constituency out there which might support change, and that only the very seriously harmed or the very seriously greedy should oppose it.

Another issue is that everyone wants doctors to be able to continue taking care of patients with Medicaid, the uninsured and the underinsured, and to forego balance billing voluntarily for elderly on limited incomes. What if the state were to indemnify physicians against professional liability suits for care of any or all of these segments of the population? Not only would we preserve access to care for these populations, but for the first time, the state would be sued for physician professional liability. After they pay for a few of these suits, we would have a powerful ally in our fight for changing the tort laws. A form of this legislation has been passed in Missouri, and we intend to work for it in Michigan.

What does the public want from us? They want to feel they are receiving the highest possible quality care, at the most cost-effective prices, with assurances that there are no bad doctors in the profession. They also would like all this without paying for it.

Third party payers, which include government, business, and all sorts of PPOs, HMOs, and hybrid managed care arrangements, also want *control*. They want to control physicians, hospitals and all other health care workers, and they want to be able to market themselves successfully to employers. To do this, they want to purchase medical care for their covered patients at a discount, and they want the providers of care to be limited in number, carefully screened before they sign up, and working on contract. In order to keep employers and employees happy, they want mandatory participation by health care professionals, and little or no out of pocket expenses for patients to pay. They also want to make a profit. Incidentally, at whose expense do you think they would like to make this profit? Yours and mine. Here is a clear example of conflicting interests.

Here is also an opportunity for a wise profession to use our knowledge to try to

reconcile these interests. All of us want to rid the profession of those members who discredit it. We all can support well-thought-out proposals for changing our disciplinary system. All of us can benefit from enhanced quality assurance systems, from the development of practice parameters or guidelines, and from worthwhile risk management programs. We can support these, and our friends the third party payers *should* support these, because they will help them too. Wisdom lies in teaching the public and the third party payers that quality saves money. The converse is that attempts to buy goods at cheap prices usually means the purchase of shoddy goods, and shoddy goods *never* saves anybody money.

If we do not want *mandatory* participation in Medicare or in Blue Cross Blue Shield, or if we do not want *mandatory* malpractice insurance in this state, we need to show how any or all of these mandates would harm the *public*, not how they will harm us. If we cannot do so convincingly, we will be on shaky grounds when we try to make our arguments. The assertion that any of these will deprive the public of access to medical care will be interpreted by the public as a threat to withdraw services if we do not get our way. If we explain that opposing these mandates may be a matter of survival for some doctors, we will have to have facts and figures to back ourselves up, because the reaction of the typical patient is disbelief.

Our friends of the Federal Trade Commission and the Justice Department provide a good example of public demands which we may not have to listen to with such great respect. The public, as repre-



Outgoing MSMS President Robert E. Paxton, M congratulates Susan H. Adelman, MD, the first woman to serve as MSMS president in the association's 125-year history.

sented by its institutions in Washington, apparently thinks that it is worse to let physicians get together to negotiate fees with third party payers than it is to let third party payers unilaterally set physician fees. Therefore, the FTC and the Justice Department are now enforcing the anti-trust laws widely against physicians. Insurance companies, however, have a legal exemption from these laws. This is not an example of either the public or the customer always being right. This is an example of them being misled, and it is an injustice perpetrated by the Justice Department. Physicians have as much right as anybody else does to a level playing field. If we need a labor union exemption to the anti-trust laws, then that is what we need. Certainly what we need is a change in the way the anti-trust laws are interpreted today, and there is no good evidence that this change would not also serve the interests of our patients.

Physician control a key goal in the 90s

If we are to have change in the next decade, and we are, what do *we* want to change? Above all, we want the ability to control the quality of care we give our patients. We do not want this quality dictated by insurers, by clerks, by cookbooks, or by Washington. We want assurances that the highest quality students will be attracted into the medical profession, and we want to know that there is an adequate source of funding for their education. We want to be able to rid our profession of those who are not up to its demands. We want to reeducate those who have fallen behind and rehabilitate those who have fallen into trouble but who have the capacity to fully recover. We want the ability to advance medical science, and to progress to ever more astute diagnoses, more effective treatments, less painful care, and ultimately to the ability to prevent disease, instead of just patching things up when they already are damaged.

We want a working environment that protects our mental and physical health, that does not waste our precious time with noxious paperwork, and that does not threaten our future and that of our families with potential financial ruin if a treatment goes wrong. We want assistance with the increasingly complicated demands of running a modern medical practice. We want fair compensation for our efforts, and if a payer has the right to offer us a payment, *we* want the right to negotiate fairly with that payer in order to arrive at our fee.

We want a clean, healthy environment in our state, free of preventable health hazards. We want clean air, safe drinking water, strict pollution control measures, and safe ways to dispose of solid and hazardous wastes. Medicine should be in the forefront of these efforts. The health of the environment is the health of people. In the next year, MSMS will become partners with our colleagues in public health and enter into the battle to clean up our environment. We challenge the auto industry and the other major manufacturers in Michigan to do the same. We do not want to hear about any of their health care costs until they are doing everything they can to keep from polluting our state and making everybody sick. It might even lower their health care costs.

Other goals

What else do we want? We want our patients, our colleagues, and our children free of drugs. We do not want them in jail, we want them educated, in time, about the hazards of drugs, and we want them treated in a network of treatment centers that covers our state, and eventually our nation. Next year, MSMS will become actively involved with drug education in the schools, and even closer to home, we will begin an intensive campaign to educate doctors. We hope to build up a curriculum and a program to teach all doctors about the diagnosis and treatment of chemical dependence, the proper referral of affected patients, and how to safely and prudently prescribe pertinent drugs. If we do not know, who will?

Finally, we want the ability to care for our patients who have catastrophic illnesses without the fear they will be financially ruined by our treatments. This means that we want coverage for the treatment of AIDS and for expensive technology which benefits our patients. Where *choices* have to be made among treatments because of financial limitations in the system, we want patients and payers to participate in these choices *with* us, not to try to off-load their rationing decisions on us.

Now that we have entered the 1990s, it will only be ten years until the next millennium. Let the year 2000 be a millennium in which we have finished with the worst of times, and in which we can look forward to the best of times. Let it be a far, far better thing that we do than we have ever done, and let it *become* a far, far better world than we have ever known. Thank you. ■

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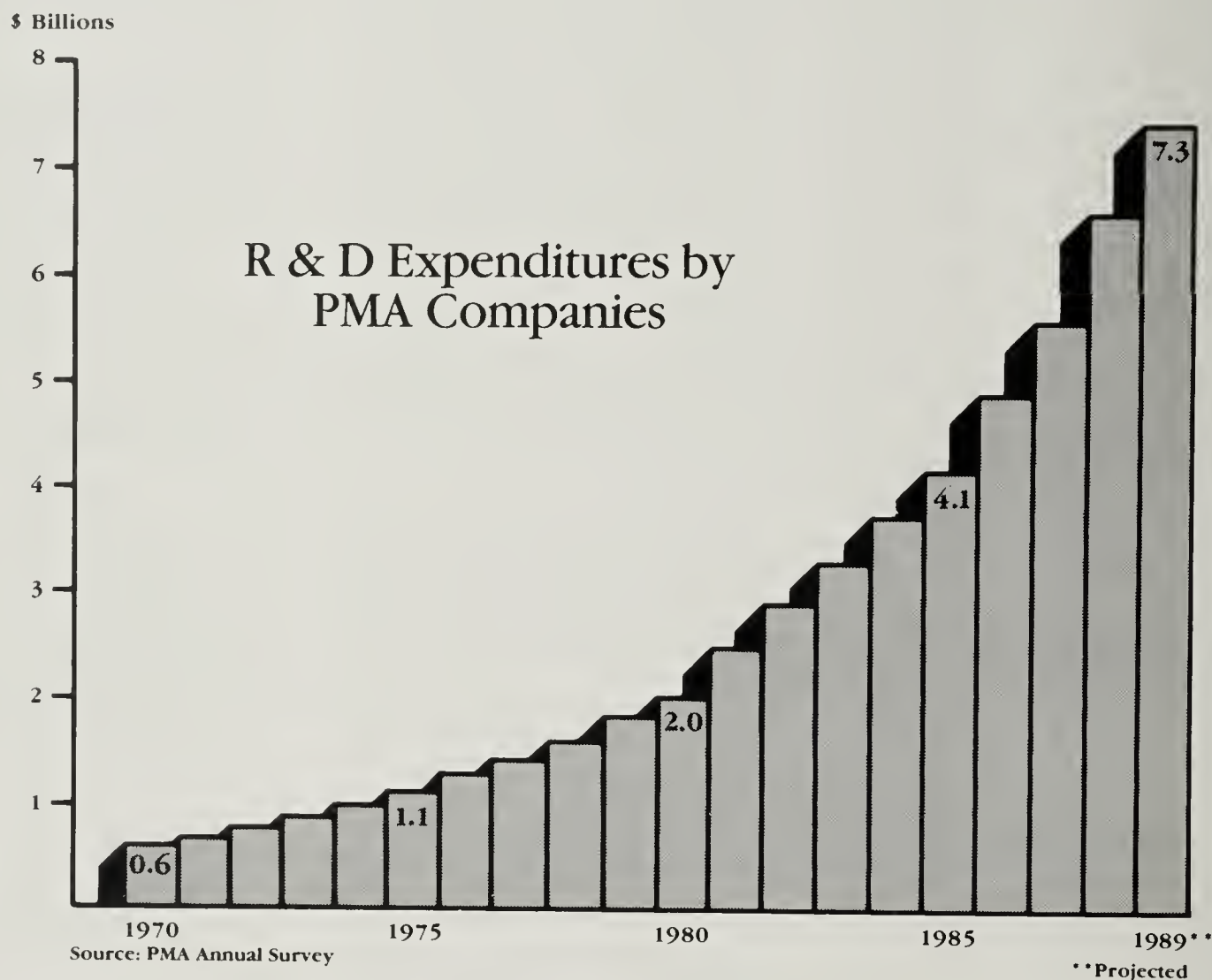
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REFINING THE ART OF INSURANCE

Remarks of the Chairman of the Board

— Frank B. Walker, MD



Frank B. Walker, MD

It has been a busy year, as evidenced by the volumes of paper in your Delegates Handbook. Among these many pages is the Annual Report of the Board, which includes both Informational and Action sections. There are 16 actions reports contained in the report on items referred to the Board by the 1989 House of Delegates; each has been considered by the Board and has been referred by your Speakers to an appropriate reference committee of this 1990 House for discussion tomorrow and action on Sunday. At its meeting this afternoon the Board acted on four additional reports, 17-20, which you received in a separate packet at registration. These reports deal with mandatory liability insurance, prescription drugs, generic labeling and recognition of the Michigan Vascular Society.

The informational reports cover a wide variety of issues that have been discussed by your Board of Directors during the past year. Time does not permit more than a brief listing of some of the issues and activities mentioned in the report of the Board. If you haven't read these reports, please be sure to do so. They

provide essential background on the many issues the House will be considering. Among the topics are:

- the communications and professional relations programs, particularly our new public relations effort called the CARING campaign;
- physician licensure and discipline initiatives;
- Blue Cross Blue Shield physician contract and MSMS Advisory and Liaison Committees with BCBSM;
- legal activities, including the filing of eight amicus briefs;
- legislative activities, including proposed bills on mandatory assignment for Medicare and expansion of scope of practice for non-physician groups, and adopted bills on disposal of infectious medical waste, use of anabolic steroids, and regulation and safe use of all-terrain vehicles (ATVs).

To expand on just one of these issues, on May 10, MSMS will be hosting a special Capitol visitation program which will, hopefully, bring many of you and your spouses to the State Capitol to discuss the mandatory Medicare assignment issue with your legislators. We need to let them know that mandatory assignment is unacceptable, and is not the answer.

There seems to be a growing consensus in the legislative arena that relief from the high cost of medical liability insurance can only be accomplished through a study of non-tort alternatives.

Your President, Bob Paxton, has been very involved and influential in these discussions. I would like to call upon him now to update us on what has been taking place in Lansing on this issue.

Additional informational reports have been submitted detailing MSMS activities on AIDS; liaison with a number of

statewide medical and non-medical organizations and with our medical specialty societies and special sections; and a new MSMS membership recruitment campaign for residents — the resident/mentor campaign.

At its meeting this afternoon the Board discussed the physician contract approved by the BCBSM Board on April 26. Our legal counsel, Dick Weber, will provide a comprehensive update on this contract at the special meeting of the House of Delegates at 7:45 a.m. tomorrow.

The Board approved an action report recommending that no action be taken on the Report of the special Ad Hoc Committee on Physician Licensure chaired by Representative David Gubow. The Board of Directors voiced strong concern to several recommendations outlined in the report of the House Ad Hoc Committee on Physician Licensure. The Board believes MSMS should carefully monitor discussions that will eventually take place as legislation is introduced.

The Board also approved a recommendation that MSMS explore the feasibility of legal action against the state Medicaid program, by working with the Michigan Department of Social Services, the Michigan Department of Public Health, and Medicaid Recipient Advocacy Groups, to verify the problem of insufficient access to obstetric and pediatric services for Medicaid recipients. The Board will review information regarding the extent of the problem of access to services at its midsummer meeting. Billy Ben Baumann, MD, is the MSMS Treasurer. He will speak to you on the fiscal stability of the Michigan State Medical Society.

I hope all of you will remember another long-time treasurer of MSMS, Leland E. Holly, MD, of Muskegon. In 1987, Doctor Holly semi-retired and at that time decided to relinquish many of his commitments to MSMS. To honor Doctor Holly for his long, dedicated service to MSMS, at its 1989 midsummer Board meeting

your Board elected to name Doctor Holly President-for-a-Day on July 22. At this time, Mr. Speaker, I would ask the 1990 House of Delegates to ratify Doctor Holly's award.

At its meeting earlier today, as specified in the MSMS Bylaws, the Board of Directors nominated the following persons for MSMS offices:

- Secretary — Thomas R. Berglund, MD
- Treasurer — Billy Ben Baumann, MD
- Assistant Secretary — Justin L. Sleight, MD
- Assistant Treasurer — B. David Wilson, MD

I submit these nominations to the House, Mr. Speaker, to be acted on at the time of elections on Saturday afternoon.

During the past year, the Board of Directors has been assisted in its many tasks by dedicated chairmen and members of task forces and committees and by our very able staff at the medical society. I want to thank them for all their efforts. In this House of Delegates you will be considering many important issues and your Board of Directors will be responsible for implementing your decisions. We will do our best to fulfill the goals you set for us.

Finally — let me say thank you. Tonight marks the opening session of my 28th year of MSMS annual meetings, nineteen as an alternate delegate or delegate from Wayne County and the past nine as a member of the MSMS Board of Directors. During this time, I have had the pleasure of knowing and working with five executive directors and have reviewed, discussed and acted on more reports and resolutions than either you or I care to count. These years have been both frustrating and fulfilling, but always exciting. I am indeed grateful for the trust you have placed in me, particularly in these past two years as Chairman of the Board. I will continue to represent you on the AMA Board of Trustees to the best of my abilities.

The Michigan State Medical Society is a great organization. We have accomplished many things of which we can be proud. I remind you, however, that we still have much unfinished business ahead. This meeting would be a great place to begin! Thank you all once again. ■

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"Your partner in practice."



MSMS Board members take a moment during the 1990 MSMS House of Delegates meeting to gather outside the Amway Grand Plaza for a quick photo.

Since the House of Delegates met last May, the Board, officers, committees, task forces and staff have been carrying forward many issues important to MSMS members. In addition, routine activities of the Society have been continued.

This year a major focus has been communication – with the public, with the profession, and with other MSMS audiences. In addition, as has been true for the past few years, professional liability has consumed much of our time and energy. Other important concerns have been membership recruitment, medical licensure and discipline, BCBSM activities, and cost containment initiatives.

While many ongoing activities are mentioned in this report, they are not discussed in great detail. MSMS members are kept informed about these matters through MSMS publications, conferences, component society visits and the special briefings for delegates and alternates.

This year's report is in three parts:

Part I – Action Items – These reports present recommendations about the items the House of Delegates referred to the Board in 1989.

Part II – Informational Items – This section notes several Board and MSMS activities of interest to the Delegates. None require House action.

Part III – Committee summaries – a list of committees and task forces which have reported to the Board throughout the year. Summaries of Activities for these groups are contained in the Delegates Notebook. (*Editor's note: Committee summaries have been omitted from the following report.*)

The Board and the officers have carried out House policy to the best of their ability during the year. Where there was no previous policy or where the policy was unclear, the Board has taken what it believed to be necessary and appropriate action. These policy actions are listed at the end of Part II of this report.

In the process of developing this report, the Board and the officers always are much aware of the hard work, competence and dedication of the members of the many MSMS task forces and committees, as well as the MSMS staff. Without this support, the Board would not be able to carry out its duties, and acknowledges with thanks and sincere appreciation this essential support.

Part I – Action Items

Action Report #1: Resolution 28-88A – Payments to Plaintiffs Attorneys

RECOMMENDATION: That the House of Delegates adopt this report, in lieu of the 1989 Board Action Report #6.

1989 Board Action Report #6 described the efforts of the Board via the Task Force on Professional Liability to seek agreements from Michigan Physicians Mutual Liability Company (MPMLC) and Physicians Insurance Company of Michigan (PICOM) that the companies would require their defense attorneys to routinely send copies to defendant physicians of their billings to the insurance companies. The Board reported to the 1989 House of Delegates that the Task Force had met with representatives from both MPMLC and PICOM, and both companies agreed to send cost of defense and settlement information upon request to their defendant physicians. The House, however, was not satisfied with this compromise and send Report #6 back to the Board for further action.

The Task Force on Professional Liability this year again met with both MPMLC and PICOM to discuss this matter. Both companies have now agreed to instruct their defense attorneys to routinely send copies of their billings to defendant physicians. We feel we have met the instructions of the House of Delegates.

Reference Committee D on Professional Liability recommended Board Action Report #1 be adopted as retitled.

The House approved the recommendation of the Reference Committee.

Action Report #2: Resolution 6-89A – Law Review for Michigan Physicians

RECOMMENDATION: That the House of Delegates adopt this report in lieu of Resolution 6-89A.

Resolution 6-89A (referred to the Board of Directors for study) asked MSMS to develop and distribute educational materials concerning physician ownership of health care services and facilities.

The Board referred the issue to the Committee on Medical Licensure and Discipline. The Committee concluded that, at this time, it would not be appropriate to develop educational materials to explain a state law that governs physician ownership of health care services and facilities.

The Committee was advised that the AMA guidelines concerning physician ownership of health care services and facilities provide that a physician's activities must be in strict conformance with the law. Section 16221 of the Michigan Public Health Code provides that it is "unprofessional conduct" for a physician to direct or require "an individual to purchase or secure a drug, device, treatment, procedure or service from another person, place, facility, or business in which the licensee has a financial interest." The Committee was advised by MSMS Legal Counsel that Section 16221 has not been interpreted by any appellate court in Michigan to date. As a result, there is no judicial precedent to guide physicians in determining the meaning of this law.

The Board supports the recommendation of the Committee.

Reference Committee B on Legislation recommended Board Action Report #2 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #3: Resolution 14-89A – Health Professionals Recruitment Strategy

RECOMMENDATION: That the House of Delegates adopt this report in lieu of Resolution 14-89A.

Resolution 14-89A (referred to the Board of Directors for study) called on MSMS to support legislative proposals that would establish a health professional recruitment strategy in Michigan to address health care needs in underserved areas of the state.

The Board referred the issue to the Committee on State Legislation and Regulations. The Committee recommended that MSMS support Senate Bill 393, which would establish a school loan repayment program for certain health professionals that agree to provide health care services in under-served areas assigned by the Michigan Department of Public Health.

The Committee was informed of numerous studies that showed that the poor and minorities, as groups, are in worse health than non-poor and non-minorities, in part because they often live where health care providers are in short supply. Senate Bill 393 would address the pressing need for primary health care service in certain locations, especially central cities and rural areas. On February 28, 1990, Senate Bill 393 was signed into law by the Governor.

The Board agreed with the Committee's recommendation.

Reference Committee B on Legislation recommended Board Action Report #3 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #4: Resolution 28-89A – Pursuit of Mandatory State and County Membership

RECOMMENDATION: That the House of Delegates adopt this report in lieu of Resolution 28-89A.

Resolution 28-89A (referred to the Board of Directors for study) asked that MSMS continue aggressive pursuit of mandatory state and county membership for licensure in Michigan.

The Board referred the issue to the Committee on Medical Licensure and Discipline. The Committee concluded that it is not politically feasible, nor appropriate at this time, to have the state licensing and disciplinary authority transferred to MSMS.

The Committee was advised that the special Ad Hoc Committee on Physician Licensure examined the issue of transferring to MSMS the state licensing and disciplinary authority. However, because of concerns expressed with the system for licensing and disciplining attorneys in Michigan, the Ad Hoc Committee recommended that MSMS not be granted such authority at this time and that changes be made to the current Michigan Board of Medicine system.

The Board agreed with the Committee's recommendation.
Reference Committee B on Legislation recommended Board Action Report #4 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #5: Resolution 32-89A – Hold HMO Harmless Clauses

RECOMMENDATION: That the House of Delegates adopt this report in lieu of Resolution 32-89A.

Resolution 32-89A (referred to the Board of Directors for study) asked that MSMS oppose state or federal laws that would allow HMO's to have "hold harmless" clauses, which would abrogate their responsibilities to both patients and providers in case of insolvency. The resolution also requested that MSMS encourage enactment of legislation in Michigan that would require HMO's to develop a "guaranteed fund" to pay providers the claims rendered for patient care before HMO insolvency has been declared.

The Board referred the issue to the Committee on State Legislation and Regulations.

MSMS is currently participating with an HMO work group established by Senators John Schwarz, MD, and William Sederburg to draft legislation that would amend the HMO laws in Michigan. The key element in the legislation is a provision that would prohibit HMO's from having "hold harmless" clauses which would abrogate their having responsibilities to both patients and providers in case of insolvency. The draft legislation also would require HMO's to develop a "guaranteed fund" to pay providers for claims rendered for patient care before HMO insolvency has been declared. MSMS is working to have this draft legislation introduced before the end of 1990.

Reference Committee A on Medical Care Delivery recommended Board Action Report # 5 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #6: Resolution 34-89A – Guidelines for Third Party and Free Standing Review Organizations

RECOMMENDATION: That the House of Delegates accept this report in lieu of Resolution 34-89A.

Resolution 34-89A asked the Michigan Delegation to the AMA to request the AMA to develop a reasonable set of uniform and effective criteria for use by the growing number of third party and free-standing review organizations.

The Michigan resolution was introduced and grouped with two others regarding PRO and Medicare screening procedures. The AMA House of Delegates adopted AMA Report PP, "AMA Initiative on Medical Review," which calls for streamlining and reducing duplication in the review programs and promoting uniformity and consistency across reviewing entities. The AMA will conduct a thorough review of a government-sponsored study conducted by the Institute of Medicine on the quality of care in the Medicare program. The AMA Board will develop and implement an action plan with the specific goals of streamlining and reducing duplication in the medical review process.

Reference Committee A on Medical Care Delivery recommended Board Action Report #6 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #7: Resolution 39-89A – Omnibus Budget Reconciliation Act of 1987 (OBRA 1987)

RECOMMENDATION: That the House of Delegates accept this report in lieu of Resolution 39-89A.

Resolution 39-89A requested that the Michigan Delegation to the AMA urge the AMA to respond to OBRA of 1987 by recommending that this ACT be either modified or rescinded with the goal of finding a reasonable solution; hospitals, third party reimbursers, nursing homes, and community health boards must all share a part of the financial burden of caring for long-term care patients undergoing the preadmission screening process.

The MSMS Committee on Aging has studied and critiqued the OBRA 1987

Preadmission Screening and Annual Resident Review Program (PASARR) for nursing home patients with the Michigan Department of Mental Health making significant recommendations. At its June 1989 meeting the AMA House of Delegates adopted a resolution calling for the repeal of the PASARR Program.

It is believed that because of strong concerns for the nursing home patient and the preadmission screening and annual resident review (PASARR) process by MSMS and AMA physicians there will continue to be federal implementation guidance changes to OBRA 1987.

Reference Committee A on Medical Care Delivery recommended Board Action Report #7 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #8: Resolution 64-89A – Discrimination in Residency Programs

RECOMMENDATION: That the House of Delegates adopt this report in lieu of Resolution 64-89A.

Resolution 64-89A was referred to the Board of Directors for study. It directed MSMS to study practices of graduate medical education programs in Michigan with regard to acceptance of graduates of foreign medical schools, and called on MSMS to establish programs to help graduates of foreign medical schools apply and interview for residency programs. The Board appointed a Task Force Re GFMS Discrimination/Residency Programs to review the issue.

The Task Force members surveyed all residency program directors in Michigan, gathered national data, and recommended that MSMS take the following actions on behalf of those who are U.S. citizens or who have obtained immigrant status and are graduates of foreign medical schools:

1. Ask Michigan residency program directors to objectively evaluate and consider all qualified applicants and not to reject any applicants solely on the basis of their being graduates of foreign medical schools.
2. Ask Michigan residency programs directors to take some graduates of foreign medical schools in their programs each year, to apply standards and qualifications uniformly, and to avoid using Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) and National Board of Medical Examiners (NBME) scores as the sole consideration in the selection process.
3. Ask Michigan residency program directors to make every possible attempt to fill every position approved in their programs, while asking the MSMS Section for Graduates of Foreign Medical Schools to define the process for monitoring the residency match system for report back to the Scientific and Educational Affairs Committee at a later date.
4. Inform Michigan residency program directors that there is no current or pending restriction on funding for graduates' medical education based upon the numbers of graduates of foreign medical schools in their programs.
5. Assert that selection for fellowship programs should be based on performance during the residency, and encourage fellowship directors not to use FMGEMS and NBME scores as sole criteria in the selection process.
6. Hold one or more seminars through the Section for Graduates of Foreign Medical Schools to assist and educate graduates of foreign medical schools on applications and interviewing processes used to obtain post-graduates training in Michigan.
7. Ask the AMA to request the Accreditation Council for Graduate Medical Education and its residency review committees not to adversely cite residency programs on the basis of the number of residents in the programs who are graduates of foreign medical schools.
8. Ask the AMA to encourage the fiscal intermediaries not to fund programs differentially on the basis of the number of residents being graduates of foreign medical schools versus graduates of LCME-accredited schools.

The Board supports the recommendation of the Task Force.

Reference Committee F on Medical Education and Miscellaneous recommended Board Action Report #8 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #9: Resolution 69-89A – Medical Liability Insurance Carriers to Provide Legal Counsel at Michigan Peer Review Organization (MPRO) Hearings

RECOMMENDATION: That the House of Delegates adopt this report in lieu of Resolution 69-89A.

This Resolution was referred to the Board of Directors for study. The Board asked the Liaison Committee with MPRO to review it. The first resolved asked

that medical liability insurance carriers in Michigan provide legal counsel at Michigan Peer Review Organizations (MPRO) hearings at no further cost to a physician. The second resolved asked that this clause be added as a rider to the physicians' insurance policies.

Three leading medical malpractice insurance companies operating in Michigan were contacted to learn if policy provisions were in existence or if the companies would be interested in establishing policy provisions at no cost to Michigan physicians.

The results of this survey indicated that one of the three companies considered providing this type of coverage during 1989 but backed away from taking any steps that would add to the cost of the malpractice insurance policy. The other two companies have not proceeded to create legal service coverage for hearings with the Michigan Peer Review Organization because of the anticipated additional expense to the carrier which would be passed along to the policy holder by way of increased premiums.

The MSMS Liaison Committee with MPRO advised the MSMS Board of Directors that it has pursued the intent of Resolution 69-89A and that legal counsel at MPRO hearings, when needed, is not available without the cost being passed on to the physician policy holder by way of an increased premium. *Reference Committee A on Medical Care Delivery recommended Board Action Report #9 be adopted.*

The House approved the recommendation of the Reference Committee.

Action Report #10: Resolution 88-89A – Necessary Testing in the Physician's Office

RECOMMENDATION: That the House of Delegates adopt this report in lieu of Resolution 88-89A.

Resolution 88-89A (referred to the Board of Directors for study) asked MSMS to oppose any legislation which would limit physicians testing done in necessary evaluation of the patient. The Resolution also requested that the Michigan Delegation ask the AMA to oppose such legislation.

The Board referred this issue to the Committee on Medical Licensure and Discipline. The Committee concluded that MSMS should oppose any legislation limiting physician office testing that may be introduced in the state legislature.

The AMA has been asked by the Michigan Delegation to monitor the implementation of the regulations passed by Congress regarding "Physician Office Testing."

The Committee was informed that there is no pending state legislation that would restrict physician office testing and MSMS does not anticipate the introduction of such legislation in 1990. The Committee recommended, however, that MSMS should oppose any legislation limiting physician office testing that may be introduced.

The Board agreed with the Committee's recommendation.

Reference Committee B on Legislation recommended Board Action Report #10 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #11: Resolution 97-89A – Publication of Disciplinary Actions of the Michigan Board of Medicine

RECOMMENDATION: That the House of Delegates adopt this report in lieu of Resolution 97-89A.

Resolution 97-89A (referred to the Board of Directors for study) called on MSMS to review actions of the Michigan Board of Medicine and to render a decision as to the appropriate publication in *Michigan Medicine* of consent and stipulation of orders of reprimand. The MSMS Committee on Publications was requested to review this issue. After hearing from Charles C. Vincent, MD, former Michigan Board of Medicine Chairman, the Committee concluded that Board of Medicine actions should be printed in *Michigan Medicine*, with the exception of actions which only reprimand physicians.

The Board agreed with the Committee's recommendation.

Reference Committee B on Legislation recommended Board Action Report #11 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #12: Resolution 101-89A – BCBSM Fee Schedules in Difference Practice Settings

RECOMMENDATION: That the House of Delegates adopt this report in lieu of Resolution 101-89A.

Resolution 101-89A (referred to the Board of Directors for study) asked that MSMS review the problem of different fees for the same procedure with BCBSM and attempt to negotiate more equitable payment for the same procedure regardless of where it is performed.

The Board referred the issue to the MSMS/BCBSM Liaison Committee. The Committee concluded that staff should request specific examples of differing

fees from the physician who introduced the resolution and discuss with BCBSM. Staff also requested clarification of policy from BCBSM.

BCBSM initiated an "ambulatory surgical incentive" program in 1983, which provided reimbursement incentives to perform certain surgical procedures on an outpatient basis. These procedures were reimbursed at 100% maximum screen for ambulatory setting, at 110-112% in the office setting and at a lower than 100% level in the hospital setting. The program was expanded in 1988 to approximately 300 procedures.

An April 1, 1988, BCBSM directive with the preceding information and a list of procedures included as ambulatory surgical incentives was sent to all physicians and hospitals.

MSMS should continued to support equitable payment for the same procedure. To address the issue of equitable payment, the Committee needs specific information from physicians in order to facilitate communication with BCBSM. *Reference Committee A on Medical Care Delivery recommended Board Action Report #12 be adopted.*

The House approved the recommendation of the Reference Committee.

Action Report #13: Resolution 122-89A – Regulation of Tanning Facilities

RECOMMENDATION: That the House of Delegates adopt this report in lieu of Resolution 122-89A.

Resolution 122-89A (referred to the Board of Directors for study) asked that MSMS support an educational campaign to secure appropriate regulation for tanning parlor facilities.

The Committee was informed that Senate Bill 661, introduced by Senator Jack Faxon, would require tanning facilities to provide an information sheet concerning the risks of using tanning facilities to all customers. The bill would also require an employee of the tanning facility to be present during business hours to assist each customer in the proper use of the tanning devices. Finally, the bill would require the owner of the tanning facility to promptly report each injury or complaint of an injury that occurs in the tanning facility to the Michigan Department of Public Health.

The Committee has recommended MSMS support of Senate Bill 661 and is currently working with members of the Senate Health Policy Committee to gain passage of this legislation.

The Board agreed with the Committee's recommendation.

Reference Committee B on Legislation recommended Board Action Report #13 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #14: Resolution 138-90A – Reporting to Licensure Board

RECOMMENDATION: That the House of Delegates adopt this report in lieu of Resolution 138-89A.

Resolution 138-89A (referred to the Board of Directors for study) asked MSMS to seek amendments to Michigan laws requiring investigation of physicians by state licensure boards, so that the investigation would occur only according to specific criteria established by the Michigan Board of Medicine.

The Board referred the issue to the Committee on Medical Licensure and Discipline. The Committee concluded that specific criteria for investigations of physicians should be developed by the Michigan Board of Medicine as soon as possible.

The Committee was advised that any physician who has at least three malpractice suits filed against him/her in a ten-year period or has a judgment entered against him/her for at least \$250,000 will be investigated by the Malpractice Unit of the Department of Licensing and Regulation. The Committee was also informed that MSMS has contacted staff in the Department concerning this issue, but the department opposes changes in the law at this time.

The Board agreed with the Committee's recommendation.

Reference Committee B on Legislation recommended Board Action Report #14 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #15: Resolution 145-89A – National Health Service Corporation Programs in Michigan

RECOMMENDATION: That no further action be taken on Resolution 145-89A.

This resolution was referred to the Board of Directors for study. The Board asked the Hospital Medical Staff Section to review it. The resolved portion asked MSMS to evaluate the possibility of developing a Health Service Corporation program in Michigan.

The resolution was discussed by HMSS representatives and by the MSMS/HMSS Governing Council where it was reported that considerable concern has been voiced by physicians presently practicing in underserved areas. Although these physicians would welcome new physicians to the area, they do not believe that the new physicians should enter practice in competition with existing physi-

cians, on a subsidized basis. The existing and potential legislation that would establish policy and guidelines for programs of this nature was reported. It was the consensus of HMSS representatives from urban underserved and rural underserved areas that there is a strong division of opinion regarding the establishment of a Health Service Corporation in Michigan.

The MSMS/HMSS Governing Council recommended and the Board concurs that, in consideration of potential legislation on this matter, the House of Delegates take no further action toward creating a Health Service Corporation Program in Michigan.

Reference Committee E on Public Health and Miscellaneous recommended Board Action Report #15 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #16 Resolution 154-90A – Stop Michigan Blue Cross Blue Shield from Joining the Plaintiff in Medical Liability Cases

RECOMMENDATION: That the House of Delegates take no further action on this resolution.

Resolution 154-89A (referred to the Board of Directors for study) asked that MSMS find in how many cases Blue Cross Blue Shield of Michigan has joined the plaintiff as a third party against a physician and that MSMS take steps to stop Blue Cross Blue Shield of Michigan from joining the plaintiff in placing the physician in an adversarial position.

The Board referred the issue to the MSMS/BCBSM Liaison Committee. The Committee reviewed this resolution and indicated there is no legal problem.

The Committee also reviewed the BCBSM Litigation Department's letter dated May 11, 1989, regarding this resolution. The Committee accepted the Litigation Department's explanation of its activity as a silent party in conjunction with any proceedings which are directed towards settlement. The Committee also recognized the 1986 tort reform law which permits an injured plaintiff to recover from the defendant provable damages including reimbursement. The MSMS/BCBSM Liaison Committee determined that, in consideration of the legal information presented on this matter, the MSMS Board of Directors take no further action to attempt to stop Michigan Blue Cross Blue Shield from joining the plaintiff in such determination.

Reference Committee A on Medical Care Delivery recommended Board Action Report #16 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #17: MSMS Policy re: Mandatory Insurance

RECOMMENDATION: That MSMS leadership be given the authority to negotiate with the Governor's factfinders their requirements for mandatory insurance or its equivalent, if necessary, to obtain significant tort reform.

MSMS continues to work with Robben Fleming who represents the Governor as his malpractice factfinder. It is too early to draw conclusions from this process. Of the items being discussed by Robben Fleming the proposed options call for mandatory arbitration for all cases with a disincentive for those who will not accept the verdict and opt to go to court. Most importantly Robben Fleming has repeatedly discussed the need for an upper limit on payment based on the severity of injury. Throughout the discussions with Robben Fleming, MSMS has urged modification of the original proposal which called for a complex, extensive, state-wide physician competency assurance program.

MSMS has argued that a more appropriate arena for the discussion about licensure and discipline may be through our policy discussions related to the special House Committee on Medical Licensure and Discipline, a bi-partisan committee chaired by Representative David Gubow. During our discussions with Robben Fleming, it has been made clear current MSMS policy opposes mandatory insurance requirements. It has been stressed that mandatory insurance requirements could only be discussed if a proposal is developed to provide for reasonable premiums for adequate coverage. We continue to stress the example that states contiguous to Michigan are paying much lower rates for equivalent limits of insurance.

In the legislative arena, MSMS has worked with Senate leadership to hold hearings on Senate Bill 323. Senate Bill 323 would expand the Good Samaritan Act to those situations where a physician/patient relationship has not been established prior to medical treatment. Most recently the Michigan Department of Public Health and the Michigan Department of Social Services have shown interest in developing a Medicaid service liability fund to pay premiums for those physicians who provide care for Medicaid patients.

It is now clear that both the State Departments are realizing that patient access to care has diminished as a result of the liability climate in Michigan.

Currently MSMS is working on a number of other fronts in order to improve the professional liability climate in Michigan. Most recently the MSMS Board of Directors approved the initiation of legislative efforts by the Michigan State Medical Society and the Michigan Hospital Association to secure introduction and passage of the Michigan Medical Liability Determination Act. The Michigan Medical Liability Determination Act would:

Combine a determination of fault made either by the courts or via a new administrative mechanism with a schedule of damages which applies in either instance. Adoption of the proposal would lead to a more timely and predictable outcome to a medical liability claim, with savings possible from the use of a schedule of damages together with the possibility of substantially reducing transaction costs.

The proposal envisions the creation of a Medical Liability Determination Board. It is hoped that the retention of the right to a trial to determine fault will satisfy any constitutional right to a trial by jury.

Reference Committee D on Professional Liability recommended Board Action Report #17 be adopted be amended.

The House approved the recommendation of the Reference Committee.

Action Report #18: Resolution 111-89A – Schedule II Prescription Drugs

RECOMMENDATION: That the House approve this action report in lieu of Resolution 111-89A.

Resolution 111-89A asked that the MSMS Board of Directors evaluate the drugs currently included in the triplicate prescription requirement and take appropriate action in the study of other drugs which should be included.

The Committee on Medical Licensure and Discipline examined this resolution. The Committee believes that, in general, only Schedule II prescription drugs should be included in the triplicate prescription requirement. The Committee was advised, however, that HB 4081, which passed both the House and the Senate, would require physicians to use triplicate prescriptions when prescribing anabolic steroids. While there have not been significant problems in the implementation in the triplicate prescription requirement, the Committee believes it is premature to extend the triplicate prescription requirement to additional drugs at this time. The Committee will continue to closely monitor this issue and if appropriate, will recommend that additional drugs be subject to the triplicate prescription requirement.

Reference Committee B on Legislation recommended Board Action Report #18 be referred to the Board for further study.

The House approved the recommendation of the Reference Committee.

Action Report #19: Resolution 132-89A – Generic Labeling

RECOMMENDATION: That the House approve this action report in lieu of Resolution 132-89A.

Resolution 132-89A asked that MSMS request the appropriate state agencies to require the indication of both brand and generic names on the label of dispensed non-combination medications. The resolution also asks that MSMS urge the appropriate state agencies to require the indication of dispensed brand name and most common brand names on all dispensed combination medications.

The Committee on Medical Licensure and Discipline reviewed this resolution. The Committee was advised that MSMS has drafted a letter expressing its concerns to the Michigan Department of Licensing and Regulation and the Michigan Board of Pharmacy asking that they explore this issue.

Reference Committee B on Legislation recommended Board Action Report #19 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #20: Recognition of the Michigan Vascular Society

RECOMMENDATION: That the Michigan Vascular Society be recognized for representation in the MSMS House of Delegates and that the MSMS Bylaws, Section 20:10, be amended (on first reading) to add the name of this organization to the list of recognized specialties.

The MSMS Board of Directors has received a request from the Michigan Vascular Society that it be recognized as a specialty organization by MSMS. The Board has determined that the Society meets the criteria for recognition of specialty societies as delineated in Section 20:20 of the MSMS Bylaws: 1) A statewide specialty organization at least 5 years old; 2) 25 or more active physician members; 3) at least 70% of the physician members are members of MSMS.

The Reference Committee on Constitution and Bylaws recommended Board Action Report #20 be adopted on first reading and laid over to the 1991 House of Delegates.

The House approved the recommendation of the Reference Committee.

COMMUNICATIONS AND PROFESSIONAL RELATIONS

The introduction of the major new MSMS public relations effort, the CARING Campaign, was the highlight of the past year. The Campaign is subtitled, "a program to promote positive public perception of physicians," and had its genesis in a series of member focus sessions convened by MSMS President Robert E. Paxton, MD. Members of these sessions gave top priority to the need to improve their public image. *Time* magazine and *The New York Times* gave impetus to the Campaign with publication of two widely-read articles publicly assessing physicians' problems.

Elements of the Campaign will aid members in reaching out to patients and the public on the grass-roots level. Advisory Committee on Communications and Professional Relations members believe the greatest impact may be achieved one-on-one by individual physicians assisted in their effort by MSMS. Projects underway include spokesperson training of physicians in four targeted counties who will then serve as credible sources for local news media, schools, agencies and community service organizations. Their service may range from a letter to the editor to an interview on television. MSMS is producing six 10-second public service spots for distribution to the state's television stations. A new poster will encourage patients to ask questions of their physicians, while a new brochure will help physicians explain covered benefits of their patients' insurance programs. Other efforts include preparation of a cadre of physicians to convene community roundtable discussions on the effects of health care cost containment upon health care delivery in local communities and the direction of health care in the 1990s.

MSMS has continued to serve as a major resource for news media across the state. President Robert E. Paxton, MD, made a swing through West Michigan communities during the fall in which he visited television and radio stations and newspaper offices in seven communities in three days. The professional liability situation continues to be a focus of many media contacts. Efforts to avert mandatory assignment legislation also were high on the list of Communications support.

Michigan Medicine and *Medigram* continued to provide physicians with information about issues affecting medical care delivery and other news of MSMS members and activities.



MEDICAL LIABILITY Alternative to Tort

The Board voted on March 14 to seek legislative approval of the "Medical Liability Determination Act," an alternative plan for resolving medical liability claims. The proposed legislation is based on a model by the Physician Insurers Association of America. It combines a determination of fault, made either by the courts or via a new administrative mechanism, with a schedule of damages that would apply in either instance.

Specifically, the proposal would create a Medical Liability Determination Board. The plaintiff could choose to either file a complaint with the Board, or institute a civil action in court. If and when the fault is determined either by the Board or the court, the plaintiff is entitled to benefits as defined in the Act. These include:

- Attorney fees at a reasonable hourly rate capped at 25 percent of all other benefits if fault is determined and at one third this rate if the defendant is found blameless.
- Lost income – 70 percent of lost income capped at four times the state average weekly wage, approximately \$80,000 per year.
- Compensable dependent care – actual costs capped at the state average weekly wage, approximately \$20,000 per year.
- Medical expenses that are reasonable and necessary as incurred.
- Rehabilitative and occupational training as is reasonable in relation to probable rehabilitative effects.
- Non-economic loss payable only for permanent or severe temporary impairment (at least 180 days in duration) capped at approximately \$10,000 times the number of years of remaining life expectancy.
- Death benefits capped at approximately \$200,000.
- Lost income and compensable dependent care will be paid to a surviving spouse for up to seven years and to a dependent minor until age 18.

Governor's Medical Liability Factfinders

MSMS is working closely with the Governor's medical liability factfinders to accumulate accurate data on the liability situation in Michigan and to develop solutions that will include alternatives to the tort system.

The factfinders, Robben Fleming and Jay Rosen, released a 13-page memo February 27, 1989, recommending solutions to the states medical liability problems. The memo calls for an expanded system to assure that Michigan physicians maintain their skills, for continued development of risk management programs, for a new state agency to increase the efficiency of the adjudication system, for significant changes in the tort system, for limits on awards, for mandatory insurance, and for limits on insurer profitability.

Health Policy Agenda/ Michigan Patient Compensation Fund Demonstration Project

The Project Steering Committee is pursuing a no-fault system to compensate infants with birth-related neurological injuries. The Committee is working on a program for Michigan that is similar to the Florida and Virginia programs. The Michigan program, however, will be broader and cover cerebral palsy.

Professional Liability Coverage for Medicaid Obstetrical Care

MSMS is working with the Department of Social Services and the Department of Public Health to develop a State Legal Expense Fund, similar to that currently operating in Missouri. The fund extends governmental liability coverage to health care providers when they are rendering prenatal and obstetrical care under contract with the state. MSMS is currently seeking a sponsor for legislation to establish a legal expense fund in Michigan.

Risk Management

MSMS, along with the Michigan Physicians Mutual Liability Company (MPMLC), sponsored risk management seminars throughout the state in the spring and summer of 1989. These seminars were attended by over 900 physicians. Insured physicians from both MPMLC and Physician Insurance Company of Michigan (PICOM) who attended the seminars, were eligible for premium discounts.

The new 1990 MSMS/MPMLC Risk Management Seminars began March 28 in Lansing and will be continued throughout the state. The 1990 program is designed to increase knowledge and enhance skills in many areas including arbitration, mediation and litigation. Physicians who attend will earn premium discounts.

Limited Immunity for Emergency Care

Senate Bill 323, introduced by Senator John Schwarz (R-Battle Creek) would provide limited immunity for health professionals when providing emergency care in a hospital until a voluntary physician-patient relationship is established. The bill is still in the Senate Judiciary Committee. MSMS supports SB 323 and is working with the Michigan Chapter of the American College of Emergency Physicians, the Michigan Hospital Association, and Senator Schwarz to have a hearing scheduled on the bill. SB 323 is strongly opposed by the trial lawyers and the State Bar of Michigan.

Physician Licensure and Discipline

After holding a number of meetings and hearing from representatives of many organizations including MSMS, the Special Ad Hoc Committee on Physician Licensure appointed by Speaker Dodak has concluded that the existing system for licensing and disciplining health care professionals should be restructured. The Special Ad Hoc Committee is recommending that two separate processes be established for licensing and disciplining all licensed health care professionals in Michigan. The existing licensing boards would continue to function separately for each licensed health care professional and would be responsible for licensing and continuing education requirements. The discipline process would be combined for all health professionals, under the Department of Licensing and Regulation, and would consist of the following steps:

1. An investigation of complaints and a recommendation for action by the Department of Licensing and Regulation staff;
2. A mandatory settlement conference;
3. A formal hearing conducted by a regional panel consisting of two licensees from the same profession as the licensee under investigation and an attorney;
4. A final review of disciplinary actions by a new state discipline board consisting of five public representatives and two licensees;
5. An appeal to the Court of Appeals.

The Committee also is recommending an increase in the investigative staff of the Department of Licensing and Regulation. The increased costs would be paid for by increasing the license fee of all health professionals.



MSMS PRIORITIES FOR 1990

At its May 4, 1990, meeting, the Board of Directors considered approval of a list of MSMS activity priorities for 1990. To reinforce the importance of this list, a detailed brochure outlining each was inserted into the April 17, 1990, *Medigram*.

An abbreviated version of the MSMS PRIORITIES FOR 1990 follows. Additional copies of the complete brochure will be available through the Department of Communications and Professional Relations.

Patient Advocacy

MSMS will work in 1990 to help others involved in health care delivery and reimbursement understand what we have always known, that our patients' needs are the priority. Our new benchmark study, "Improving Michigan's Health Care System: Beyond Cost Containment to Serving Patients' Needs," emphasizes this point as does a new major initiative, the MSMS "CARING Campaign — A Program to Promote Positive Perceptions of Physicians." These two projects are part of the MSMS commitment to put our patients in the center of the health care delivery system.

Professionalism, Community Service and Quality of Care

Continuing medical education to help keep physicians up-to-date always will be an MSMS priority. The MSMS Annual Scientific Meeting, the annual MSMS Conference on Maternal and Perinatal Health and the annual Conference on Sports Medicine will draw more than 1,400 physicians and 600 nurses, students, technicians and other health care professionals, providing more than 11,000 hours of Category I CME credit to physicians.

Community service will continue to be emphasized and rewarded by MSMS in 1990.

MSMS supports the development of practice parameters under the direction of physician organizations to help assure only appropriate, high quality medical services are provided.

Health Care Cost Containment

The MSMS Board of Directors commissioned an independent report to look at the effects of past cost containment activities on our patients and to make suggestions for the direction of health care in the 1990s. The report concludes that the true bottom line is the health of our patients, not purchasers' payments or providers' revenues. MSMS will undertake a grassroots effort to set up community "roundtable" discussions about health care focused on this report, "Improving Michigan's Health Care System: Beyond Cost Containment to Serving Patients' Needs."

Chemical Dependency

A major initiative for 1990 will focus on preventing and treating drug abuse in Michigan through a variety of avenues. Discussions currently center on providing physicians statewide with information on recognizing early signs of drug abuse or addiction, on treatment protocols, treatment facilities and appropriate follow-up care. MSMS will encourage medical schools to expand curricula in drug abuse, prevention and treatment. Publicly, MSMS will work to educate vulnerable populations, particularly children, and to promote hospital-based programs for treating addicted mothers and infants.

Non-Dues Income

MSMS will continue to improve its financial base by enhancing non-dues income.

Hagadorn, Inc., a joint venture with MPMLC, will see its new 88,000 square-foot office building completed this year. The project is designed to provide long-term real estate investment income.

Physician Service Group, Inc., and the Physician Review Organization of Michigan, wholly-owned subsidiaries of MSMS, will continue to increase non-dues revenue. These activities already generate 40 percent of MSMS revenues.



LEGAL ACTIVITIES

Alternatives to the tort system continue to be studied. The Michigan Medical Liability Determination Act, derived from the Physician Insurers Association of America model, was drafted for application in Michigan. This is a fault-based administrative alternative with substantial procedural and damage reform provisions.

Legal analysis, advice and drafting relative to legislation affecting physicians was ongoing. This included legislation covering chemically-dependent physicians, emergency treatment immunity and medical licensure and discipline.

The Michigan Supreme Court adopted the arguments asserted by MSMS in its amicus curiae brief filed in *Palenkas v Beaumont Hospital*, favorably changing the law relative to remittitur. Amicus curiae briefs have been filed in support of the arguments that physicians who communicate with other treating physicians by telephone, without establishing a physician-patient relationship, have no malpractice exposure, *Hill v Hole*, and that patients and their family members have the right to determine life support medical treatment, *In re Rosebush*. In other cases in which MSMS filed amicus curiae briefs, the Supreme Court refused to overrule a decision which bars the attorney for a malpractice defendant from privately interviewing the plaintiff's treating physicians, *Jordan v Sinai Hospital*, and in *Manusco v Burns Clinic*, the Supreme Court refused to review a Court of Appeals decision recognizing a "pre-conception tort." In *Palazzo v Teasdale*, in which MSMS argued that electromyography is an inherently diagnostic procedure which constitutes the practice of medicine and is outside the scope of physical therapy licensure, a favorable settlement precluded a decision.

Legislation protecting qualified retirement plans from bankruptcy has been under attack. Some bankruptcy judges in other jurisdictions have held that such legislation is pre-empted by ERISA, and others have held to the contrary. A case is pending in the Federal District Court in Detroit on this issue and Legal Counsel will file an amicus curiae brief on behalf of MSMS in support of the validity of the Michigan pension protection legislation.

Information has been disseminated to MSMS members with respect to the National Practitioner Data Bank. Of particular significance is the potential effect of the Data Bank on the MSMS Judicial Commission and component society peer review proceedings.

An insurance agent/administrator agreement was negotiated, drafted and executed between MSMS and Stratton-Cheeseman & Associates, Inc., creating a legal relationship relative to MSMS-sponsored insurance programs. Under the agreement, MSMS will receive royalties for endorsing such sponsored programs.

Discovery and related proceedings continued in the chiropractic antitrust litigation. The case is scheduled for trial late this year.

The federal tax case is ongoing. The MDPAC issues are pending before the IRS national office in Washington awaiting a Technical Advice Memorandum. The issues relating to the disallowance of losses attributable to Michigan Medicine as deductions against unrelated business income are pending before the Appellate Division in Cleveland. Legal Counsel has filed briefs in both forums.

Legal Counsel has provided analysis and advice relative to the proposed new BCBSM Physician Provider Contract and has worked with MSMS leadership in expressing MSMS's views to BCBSM regarding the contract.



PHYSICIAN EDUCATION

MSMS continues to play a major role in the education of physicians and many allied health professionals through the presentation of conferences and seminars, through its publications and through an expanded program of jointly-sponsored CME activities with other medical groups. Programs in 1989 covered nearly every medical specialty and scientific subjects offering Category 1 Credit, as well as many topics on leadership, financial matters and practice management.

The computerized registration and recordkeeping processes for MSMS meetings have made it possible to determine physician interest from a geographical and specialty perspective so audiences can be targeted to receive specific information relative to their needs and interests. The computerized evaluation process has been developed to improve MSMS programs and to help MSMS be a better resource for individuals and organizations as they plan their own programs.

The MSMS Annual Scientific Meeting, the annual Michigan Conference on Maternal and Perinatal Health and the MSMS Conference on Sports Medicine drew a total attendance of about 1,400 physicians and 700 nurses, trainers, students, technicians and others involved in the health care field. These annual conferences alone provided over 10,800 hours of Category I CME credit to physicians. MSMS also jointly sponsored 22 CME meetings and seminars with specialty societies, county medical societies and medically-related organizations which awarded nearly 3,000 Category I credit hours to physicians.

The MSMS Committee on CME Programming cooperated in the AIDS Provider Education Project which scheduled speakers from the MSMS AIDS Speakers Bureau all across Michigan and has provided guidance to the Physician Service Group, Inc., as seminars have been developed on risk prevention and improved patient relations and communication. The Committee also was instrumental in helping the planning committees for MSMS meetings develop new teaching methods and encouraged different formats for learning.

MSMS, in cooperation with the AMA and PSG, presented many seminars for residents on setting up practice, for practicing physicians and their staff on office management and also on marketing and financial matters.



AIDS PROVIDER EDUCATION PROGRAM

The MSMS AIDS Provider Education Program, operating for the fourth year under a contract with the Michigan Department of Public Health, continues to play an important role in the Michigan response to AIDS. Two activities, the MSMS AIDS Speakers Bureau and the AIDS Medical Information Network, are prominent services provided through the program. Both are available at no cost to all health professionals in Michigan.

Since its start in 1987, the MSMS AIDS Speakers Bureau has reached over 28,000 health professionals including physicians, nurses, social workers, pharmacists, first responders, dentists and dental hygienists. More than one hundred experts throughout the state now serve as part of the Speakers Bureau, using resource materials — slides, videotapes, brochures and other written materials — provided through the AIDS program.

The AIDS Medical Telephone Information Network serves as a ready reference on AIDS for Michigan's health professionals. Technical questions are answered by a team of volunteer doctors, nurses, social workers and attorneys. Literature searches are conducted through the AMA on-line computerized information network, AMA/Net.

In addition, MSMS has published a 100-page resource guide, *A Physician's Guide: AIDS/HIV in Michigan*. Over 20 Michigan agencies, including MDPH and the East Central AIDS Education and Training Center (ECAETC), cooperated in its development. A free copy of the guide has been mailed to every Michigan physician. The AIDS Education Program will continue to offer resources to component medical societies about AIDS, and will sponsor again this year a course on AIDS at the MSMS Annual Scientific Meeting.



PHYSICIANS RECOVERY NETWORK

The Physicians Recovery Network is increasingly active as more doctors become aware of its services. PRN Medical Director Gerald A. Vander Voord, MD, now makes 25 to 30 personal contacts a month and his current caseload is over 40 active cases. Some of these active cases require personal contacts by PRN at least three times a month, some once a month, and other doctors only need to be contacted quarterly.

PRN also monitors urine testing of recovering physicians. Doctor Vander Voord

is currently monitoring over a dozen ongoing cases. He keeps a running tab of the numerous telephone inquiries regarding the PRN and reports that he never has less than five calls a day and has handled up to 16 calls in one day.

The PRN continues its advocacy role for its impaired colleagues, and Doctor Vander Voord makes himself available at meetings of the Board of Medicine and attends compliance conferences.

There have been many successes. Unfortunately, not every impaired doctor completes treatment or stays free of chemical dependency. Out of the 109 cases the PRN handled, 12 physicians have relapsed. But its success rate is 90 percent and, in comparison to national averages, PRN has a very good record.

Funding continues to be a major consideration of the Steering Committee. MSMS is grateful to both MPMLC and PICOM for their \$25,000 contributions to the program and to MAOPS for doubling its annual contribution to \$10,000. In addition, PRN submitted a prospectus for an RSVP grant to the Michigan Health Care Education and Research Foundation which has been approved. A grant application is being prepared and will be submitted requesting a \$50,000 research grant.

As the PRN grows and becomes more complex, it has become necessary to computerize its records. This data base will not only permit the PRN to maintain more accurate records on individual cases, it also will provide it with the vital statistics that can be used to evaluate the effectiveness of its efforts, identify possible factors that contribute to addiction, codify the types of addiction and impairment, etc.

The MSMS computer consultant has begun building a program to accommodate PRN's needs.

The Steering Committee on Program to Assist Impaired Physicians met on December 18 to review the impaired practitioner model developed by the Michigan Department of Licensing and Regulations which would serve as the basis for a substitute bill to HB 4712 (the impaired physician legislation which has been introduced by Representative Gubow). L&R Director William Howe and Mary McDowell, chief of its compliance unit, were present to explain their concerns and hear comments from the Committee. After much discussion, three representatives were appointed to meet with Mr. Howe and Ms. McDowell to help develop a compromise proposal that would address the concerns of both MSMS and L&R. Three joint sessions were held, and the final proposal emanating from these meetings has been approved, in principle, by the Steering Committee.



BCBSM ACTIVITIES

In implementing a series of recommendations from a special consultant group to BCBSM, a Physician's Advisory Council was created by BCBSM. Five MSMS physicians serve on this Committee which began in May, 1989, and met several times in the summer and fall of 1989.

The MSMS/BCBSM Liaison Committee has met five times thus far to review individual complaints with BCBSM and facilitate their resolution. In addition, MSMS staff provided information to and directly assisted many physicians in resolving reimbursement problems with BCBSM regular business and with Medicare, for which BCBSM serves as the Part B carrier.

On September 1, 1989, BCBSM met with various Western Michigan legislators and physicians in Grand Rapids. Several additional meetings were developed from this original gathering to set in place a structured and time sequenced forum in an attempt to resolve provider and patient problems with BCBSM. This forum will continue until June 1990 in the form of a "Special BCBSM Committee."

In addition to extensive *Medigram* and *Michigan Medicine* coverage, two special mailings were made to all component society presidents and executive directors regarding MSMS/BCBSM activities. Nine Focus Group meetings between component societies and BCBSM regarding the new proposed Provider Contract were coordinated through the MSMS/BCBSM Liaison Committee.



STATE LEGISLATION

During the 1989-90 legislative year, mandatory Medicare assignment continues to be a major issue before the Legislature. MSMS has actively opposed legislation which would require Michigan physicians to accept assignment on all Medicare claims. MSMS continues to urge the Legislature to consider a voluntary Medicare assignment program, similar to one which has been established in Midland County.

On May 10, MSMS will be hosting a special Capitol Visitation Program which will bring physicians and spouses to the State Capitol to discuss the mandatory Medicare assignment issue. MSMS will continue to aggressively oppose legislation that mandates Medicare assignment.

In an effort to seek further reform to the current professional liability insurance problem, several pieces of legislation were introduced at the behest of MSMS. These bills, designed to improve the reforms passed by the Legislature in 1986, include removing several of the exceptions placed of the non-economic damage limitation, reducing the statute of limitations for minors, allowing countersuits to be filed against the attorneys of individuals who have filed frivolous lawsuits, providing immunity for emergency for medical care in the hospitals, and placing stricter qualifications on expert witnesses. MSMS will continue to actively pursue its legislative agenda in an effort to reform the current liability situation in Michigan.

There seems to be a growing consensus in the legislative arena that relief from the high cost of medical liability insurance can only be accomplished through the study of non-tort alternatives. Responding to this awareness, MSMS is currently working to have legislation introduced which would establish a new "at fault administrative model" for resolving medical disputes. Also, MSMS has worked to have legislation introduced that will allow health insurers to offer health care policies with finding arbitration provisions. MSMS has also been successful in the appointment of a medical malpractice fact finder, Robben Fleming, to further study changes and/or alternatives to the medical liability insurance system. MSMS will continue to seek ways to improve the medical liability insurance climate in Michigan.

In February 1989, Speaker of the House Lewis Dodak appointed a special House Ad Hoc Committee on Physician Licensure and Discipline to study the current physician licensing and disciplinary system in Michigan. Recently, the special House Ad Hoc Committee released its findings in regards to reforming the current Michigan Board of Medicine process. The report recommends that a new discipline board be created. MSMS will continue to closely monitor the activities of the House Ad Hoc Committee as legislation is introduced.

MSMS continues to monitor attempts by non-physician groups to expand their scope of practice and/or gain licensure in the State of Michigan. Thus far, MSMS has been successful in delaying any action on legislation which would expand the scope of practice for optometrists. MSMS is also closely monitoring legislation which would license acupuncturists, dietitians, radiologic technologists, social workers, and respiratory therapists. Legislation has also been introduced which would expand the scope of practice for chiropractic; however, MSMS anticipates that no action will be taken on this legislation this year.

Throughout the 1989-90 year, MSMS was active in legislative and administrative discussions about the disposal of infectious medical waste. Through the efforts of MSMS, a package of bills was passed aimed at providing a tighter regulation of the handling and disposing of infectious medical waste.

MSMS also has worked with key lawmakers to gain successful passage of legislation to restrict the use of anabolic steroids in Michigan. This legislation stiffens penalties for the illegal possession, manufacture, and distribution of anabolic steroids.

In following the direction of the House of Delegates, MSMS was successful in gaining passage of legislation to regulate and promote safe use of all-terrain vehicles (ATV's) in Michigan. Through the efforts of B. Elliot Gysen, MD, MSMS has been successful in the development and utilization of a mass media campaign promoting and educating people on the safe use of ATV's.

MSMS continues its efforts to increase awareness and participation by MSMS members in the state legislative process. MSMS physicians have demonstrated an increased ability to affect legislation as it relates to the medical community.



COST CONTAINMENT INITIATIVES

During the summer of 1989 the Michigan State Medical Society commissioned Public Sector Consultants of Lansing to develop a research document describing the impact of health care costs on Michigan's system of health care. Titled "Improving Michigan's Health Care System Beyond Cost Containment to Serving Patients Needs", the original focus of the report was to delineate the reasons for the magnitude of rising health care costs in Michigan. During the development phase of the report and its subsequent outline, it became clear that a broader focus was needed on the direction of health care policy within Michigan.

The completed report cites data which has been either neglected or ignored in current literature. The report revealed health care cost issues that must be presented to consumers to provide a complete and accurate picture on the reasons for the increased costs of health care in Michigan.

MSMS is promoting a better Michigan health care system by using this document

for future development. The MSMS communications staff developed a training session with Public Sector Consultants to use this data and document in community settings, as well as in university and other public settings for debate, discussion and dialogue.

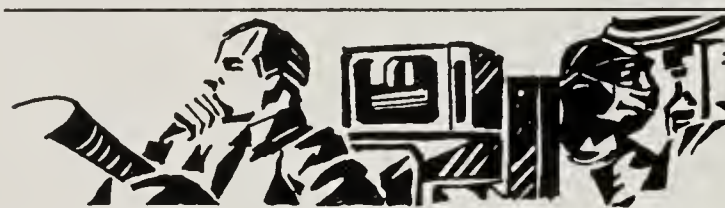
The report has been distributed to policy makers, government, major universities, health care providers, insurers and employers who impact and decide on the future of Michigan's health care system.



FEDERAL LEGISLATION

During the past year the MSMS Committee on Federal Legislation has continued to work in concert with the AMA Washington office, review federal legislative issues affecting Michigan, increase participation in MSMS Key Congressional Contact Programs, establish physician liaison with local congressional offices and to establish key contact visitation programs with congressional offices.

The MSMS Key Congressional Contact physicians have worked with the AMA Washington office in urging the Michigan congressmen and senators to oppose Medicare Budget Expenditure Targets. This was a major initiative for the AMA last year. MSMS also worked with the AMA in communicating Michigan physicians' interest in the recently enacted Resource Based Relative Value Scale. Most recently MSMS has been asked to work with the Michigan Congressional Delegation to secure co-sponsorship of legislation entitled Medicare Physician Regulation Relief Amendments of 1990 as introduced by Representative J. Roy Rowland, MD, (D-GA).



LIAISON WITH MEDICAL SCHOOLS

The MSMS House of Delegates called for the Board of Directors to develop ways to improve communication between clinical practitioners and academic physicians. Site teams, made up of MSMS Board members, were assigned to meet with medical school deans and their designated representatives to establish forums for discussion.

The site visits revealed that some issues of greatest concern affecting the practice of medicine in all settings were health care costs, funding of graduate medical education, professional liability, referral relationships, supply of physicians, the relationship between "competence" and continuing medical education, and the threat of more government involvement in licensing issues.

The site visits resulted in a closer relationship with the medical school deans and a better understanding of the major concerns and projects of their faculty and how they might relate to MSMS goals. The three medical schools are represented consistently now during the MSMS Annual Scientific Meeting and the University of Michigan Medical School now holds an annual dinner meeting there. We also have succeeded in appointing more representatives to MSMS committees.

Since Wayne State University School of Medicine appointed a new dean, Robert Sokol, MD, and with the resignation of Donald Weston, MD, Dean, Michigan State University College of Human Medicine, the next activity will be to schedule one major meeting this year and include all MSMS and medical school representatives. The spirit of cooperation fostered by this liaison may be further reinforced by a discussion of joint concerns, a collective review of progress and planning future directions.



GROUP INSURANCE TRUST

The MSMS Group Insurance Trust initiated several activities in 1989 to benefit the MSMS membership. The first of these was the commissioning of a major study regarding the sponsored health insurance program. This study was done by an outside consultant and looked at both the relationship with our current Blue Cross Blue Shield (BCBS) coverage and potential alternative carriers. The report con-

cluded, due to the particular characteristics of the MSMS insured group, at this time, it would be best to maintain the relationship with Blue Cross Blue Shield. Private carriers were only interested in the MSMS group if they could tie-bar the health insurance coverage to other types of insurance products and even then the indications were the rates would be substantially higher due to the unpredictability of the cost within the MSMS group.

The second major initiative the Group Insurance Trust undertook was a survey of the MSMS membership. This survey asked questions about different types of insurance products of interest to the MSMS membership. The survey found the vast majority of the members continue to be interested in the health insurance product. Several other products were mentioned as potential insurance programs the membership would like MSMS to offer.

Both the survey and the consultants report found the Group Insurance Trustees must continue to improve the customer service, marketing, and the relationship it currently has with Blue Cross Blue Shield. The Trustees have established an ongoing data analysis of experience of the MSMS group to establish the accuracy of the rates currently being charged. For the 1990 premium year, the MSMS group experienced no premium increase, due to a combination of reduced utilization and redesign of certain parts of the insurance program. In addition to these developments in the group insurance program, the Trust was able to negotiate a unique program for the MSMS membership. In the current MSMS-sponsored program, members and their employees have the ability to select a \$5 co-pay drug program. It is a free-standing program which members can select without it being tied to any other type of coverage or option.

The MSMS group dental program continues to show growth. This was the first association program provided by Delta Dental Plan. It remains the only opportunity for MSMS members to purchase dental coverage without being tied to any other program or type of coverage.

The Group Insurance Trust continues to review the Blue Cross Blue Shield health insurance plan and will continue to look for other modifications in the coverage and opportunities to maintain a high quality product at a reasonable premium. The Trust will continue to work to develop other types of programs to be introduced to the MSMS membership on a group basis. Within the next year, the Trustees will be working to revamp the other insurance programs offered by MSMS. As this is completed for each product, these products will be introduced to the membership in their revised form.



HEALTH EDUCATION FOUNDATION

The Health Education Foundation, established in 1946 by MSMS for the purpose of providing medical school loans to Michigan students, was redirected in 1986 to advance the field of health for the public good. Since then, the Foundation has successfully broadened its scope and perspective and is viewed as the philanthropic arm of MSMS. The Health Education Foundation also administers the James D. Bruce Fund and the Impaired Physician Loan Fund.

Interested in programs focused on health education and research, the Foundation looks for innovative funding strategies. The Trustees examine changing attitudes, ethics and values with regard to prevention, intervention and educational projects. Awarded thus far in 1990 are grants to Western Michigan University for a conference entitled "Aging in the 1990's: Alcohol and Other Drug Abuse" and to the Michigan Health Council for general operations. Several other grant requests are under review and decisions will be made at the next HEF board meeting. Under the director of its President, Robert E. Paxton, MD, HEF has continued to expand its viability and broaden its base of financial support through the formation of the Health Education Foundation Planning Committee. The Committee has explored and implemented several effective means to promote a greater awareness and support of the Foundation by the MSMS members and the public. The contributions received from the MSMS Board of Directors and the membership in 1989 exceeded \$7,000 which including a challenge gift of \$2,000. An annual report later this year will review in detail the activities of the Foundation.



LIAISON WITH OTHER ORGANIZATIONS

MSMS continues to emphasize the importance of ongoing liaison with a number

of statewide organizations. The emphasis on organization liaison is designed to seek out those issues and areas in which MSMS and other organizations can have a joint impact.

During 1989 MSMS worked with a number of organizations to achieve solutions in the professional liability climate, Medicaid reimbursement environment, public health issues, and in the area of protecting physicians' personal assets in the case of bankruptcy.

MSMS meets regularly with the Michigan Hospital Association, Michigan Dental Association, Economic Alliance for Michigan, the State Bar of Michigan, the Michigan Association of Osteopathic Physicians and Surgeons, the Michigan Council of Deans and the Michigan Board of Medicine. MSMS also meets periodically with the Michigan Pharmacists Association and the Michigan Nurses Association.

MSMS has also been very pleased with the results of its meetings with a number of the statewide specialty society organizations representing specialists in Michigan. In 1989 we met with many specialty societies and upgraded our effort to meet on a regular basis with specialty society presidents.



PHYSICIANS' ISSUES PRESENTATIONS

The MSMS/HMSS Physician Issue Presentation, Program - II, presentations have been scheduled for September 4, 1989 - May 28, 1990. The presentations have been scheduled for medical staffs at McLaren General Hospital, Flint; Genesee Memorial Hospital, Flint; Hurley Medical Center, Flint; St. Joseph Hospital, Flint; Hillsdale Hospital, Hillsdale; Mercy Memorial Hospital, Monroe; Battle Creek Health System, Battle Creek; Hutzel Hospital, Detroit; Bay Medical Center, Bay City; Alpena General Hospital, Alpena; Butterworth Hospital, Grand Rapids; Midland, Midland; Northern Michigan Hospitals, Petoskey.

The number of physicians attending has varied from almost 350 per presentation to 17 — however, this was 17 of the 18 members of the active medical staff and one physician had to cover the emergency room.

Although our HMSS Physician Issue Presentation's, our "grass-roots" communication program...will not reach 2,000 physicians as we did during our Physician Issue Presentation, Program - I series, we have recognized that it is important to speak to every medical staff, regardless of size.



MEDICAID RESOURCE BASED RELATIVE VALUE SCALE STUDY

Concern over diminishing access to primary care services for Medicaid recipients has prompted the state Medicaid program to explore new reimbursement methods. In July, the Board of Directors approved the recommendation of its Medicaid Liaison Committee to support Medicaid efforts to study the Harvard Resource Based Relative Value Scale as a means of improving reimbursement for, and access to, primary care services for Medicaid clients.

Last year, Medicaid payments for physician services averaged 43 percent of physician charges. Frustration with low reimbursement and cumbersome regulations has prompted many physicians to abandon or restrict their Medicaid practices; currently, only half of all Michigan physicians are actively participating in the Medicaid program. Declining physician participation in Medicaid has created severe access problems for Medicaid patients, particularly in primary care, obstetrical and pediatric service areas.

In the fall of 1989, the Medical Services Administration contracted with William Hsaio, PhD, author of the Harvard Resource Based Relative Value Scale Study, to assess the potential impact of the RBRVS on Medicaid fees. An Advisory Committee was also established to consult with Medicaid officials on the project. MSMS representatives to the Committee include: Gilbert B. Bluhm, MD; Donald K. Crandall, MD; Cecil R. Jonas, MD; Allen F. Turcke, MD and Daniel J. Wilhelm, MD.

Initial review of the impact of the RBRVS was based on three scenarios: the first assumed no change in Medicaid spending for physician services; the second, a ten percent increase in overall spending for physician services; and the third, no decrease in any Medicaid fees. Doctor Hsaio analyzed Medicaid claims data for 1988 for the top 100 procedures to provide preliminary information on the potential impact of using the RBRVS for Medicaid reimbursement. Analysis of all three scenarios show increases in payment for evaluation and management services; the budget neutral and ten percent spending increase analyses show reductions in pay-

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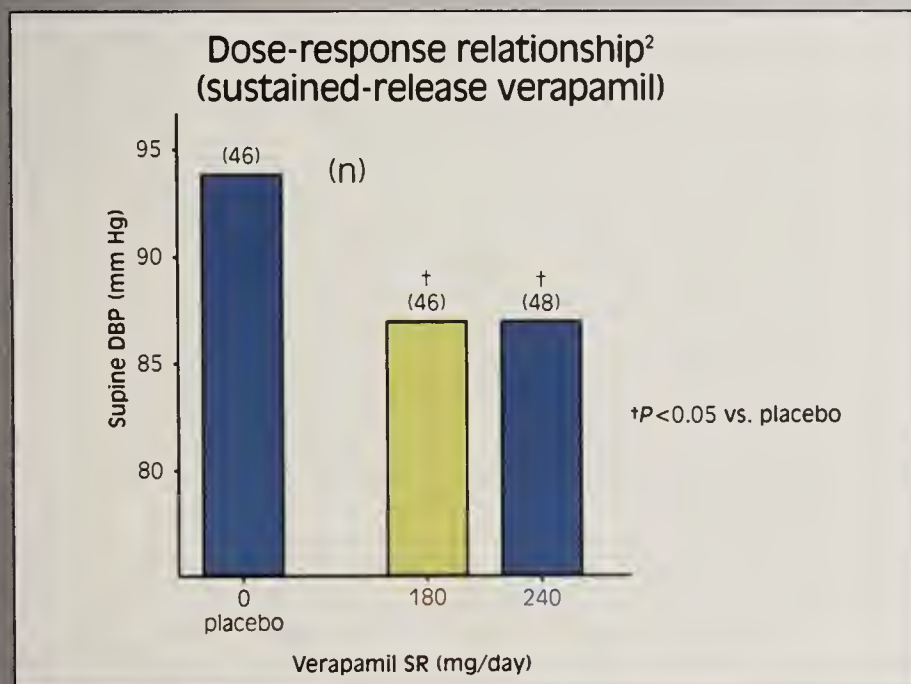


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BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol clearance may occur with combined use. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration.

Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels, increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angioedema, pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, increased urination, spotty menstrual impotence.

References:

1. 1988 Joint National Committee: The 1988 report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 1988;148:1023-1038.
2. Data on file, G.D. Searle & Co.

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nents for virtually all other categories of service. Application of the RBRVS with no decrease in any Medicaid fees would require an additional \$22 million in state spending for physician services.

Based on the initial analysis, Medicaid officials have decided to continue their exploration of the RBRVS. Further work on the project will be delayed until after Doctor Hsaio has completed work for the federal Health Care Financing Administration, and it is unlikely that any changes in Medicaid reimbursement will occur before 1992. Because the goal of the project is to improve reimbursement and access, it will not be possible to implement an RBRVS without a significant increase in spending for physician services. The MSMS Board of Directors and Medicaid Liaison Committee are developing an informational campaign about low Medicaid reimbursement and its impact on access, in an effort to garner support for the budget increases needed to assure rational implementation of an RBRVS.

MEDICARE

The Omnibus Budget Reconciliation Act of 1989 calls for further regulations on physician Medicare payments and new physician claims filing requirements. The FY90 budget is designed to meet the Gramm/Rudman/Hollings deficit target of \$100 billion, which translates for physicians to mean the 2.092 percent reduction for Part B services extends through March 31, 1990. In addition, effective April 1, 1990, it will be reduced to 1.4 percent through September 30, 1990.

There will be a 2 percent fee screen update for physicians effective April 1, 1990, for all physician services, except for the following: 4.2 percent increase for primary care services and a 4 percent decrease for radiology fee schedule services. OBRA 1989 identified 250 procedures as "overvalued" and will reduce the prevailing charges for those services up to 15 percent.

Maximum allowable actual charges (MAACs) restrictions will end December 31, 1990. In their place will be a balance billing limit. Beginning in 1991, balance billing will be limited to 125% of the prevailing or the 1990 MAAC, whichever is less. In 1992, the limit will be 120% of the fee schedule, and in 1993 and thereafter it will be 115% of the fee schedule amount.

Two additional legislative changes affecting physicians are mandatory assignment for patients eligible for Medicaid and a requirement that physicians submit all claims for their patients, unassigned as well as assigned claims. These regulations are effective April 1, 1990, and September 1, 1990, respectively.

On November 22, 1989, Congress approved legislation in which the resource based relative value scale (RBRVS) will be used to develop a new Medicare physician fee schedule. The new fee schedule will be phased in over five years, January 1, 1992 - 1996.

Congress also agreed to Medicare volume performance standards, instead of the more onerous expenditure targets, which are scheduled to become effective October 1, 1990. MVPS are designed to create an incentive for physicians to restrain the growth in volume of services provided to patients. The MVPS has only an indirect effect on future dollar conversion factor updates under the RBRVS fee schedule. If actual expenditures exceed the volume standard, the difference is not automatically subtracted from future fee updates.

HAGADORN, INC.

Hagadorn, Inc., a joint venture of MSMS and the Michigan Physician Mutual Liability Company, started construction of an 88,000 square foot three story office building in October 1989; completion is anticipated in late 1990. The anticipated start date of May 1989 was delayed while revisions were made to the building. The revisions were required because the original estimates were almost \$2 million higher than anticipated.

Ground-breaking ceremonies were held on September 20, 1989. At this time all footings have been poured, the foundation walls are up waterproofed and the erection of steel has begun.

The new building will become the headquarters for Michigan Physician Mutual Liability Company.

OFFICE COMPUTER PROGRAM

Now that the MSMS computerization project has been in operation for several years, MSMS and its subsidiaries, PSG and PROM, have contracted with Deloitte and Touche to evaluate the program at its present point.

The consultants were asked to determine whether a) the present program is adequate and whether it should be enhanced; b) whether MSMS should establish its own department of data processing; or c) whether MSMS should work with its current computer and data processing supplier to lease from them the services MSMS needs.

The Deloitte and Touche report is to be presented to the Board for evaluation within the next few months.

FINANCIAL CONDITION OF MSMS

The Finance Committee and the Board continue to meet the three-year financial plans approved by the House of Delegates in 1984 and 1987. A comparison of pro-

jected versus audited Operation Fund year-end surpluses (deficits) for both plans covering the last five years follows:

Year	Projected	Audited
FY 1985	\$ 38,400 surplus	\$(10,142) deficit
FY 1986	(93,000) deficit	(77,116) deficit
FY 1987	(260,600) deficit	(193,137) deficit
FY 1988	158,155 surplus	146,139 surplus
FY 1989	(2,425) deficit	(32,406) deficit
Cumulative	\$(157,405) deficit	\$(134,256) deficit

The Operating Budget for FY 1990 forecasts a net deficit of \$(154,896). This is consistent with the \$(165,220) deficit projected in the third year of the FY 1987 - FY 1989 financial plan approved by the 1987 House of Delegates. The Ways and Means Committee will present a new three-year financial plan for FY 1991 - FY 1993 to the 1990 House of Delegates.

POLICY ACTIONS OF THE BOARD

Since the last meeting of the House of Delegates the Board has considered some matters where MSMS policy was not clear or did not exist. In these instances, the Board has taken various actions which constitute statements of MSMS policy. These statements are listed below for the information of the Delegates. They will be incorporated in the MSMS Policy Manual along with the policy actions of the 1990 House of Delegates.

1. Michigan Health Data Corporation

The Michigan State Medical Society endorses the operating principle that data collected about physicians be analyzed and interpreted by an appropriate peer group of physicians prior to release of that data. The MSMS Board of Directors supports the Michigan Health Data Corporation's efforts to accumulate and make available to the public through public reports, employer, insurer and physician data. MSMS agrees to assist in providing grouped physician data under public reports in the future once hospital and grouped purchaser data is provided under the negotiated category.

MSMS intends to assist MDHC in moving toward the concept of the "near term" and "ideal" categories. It is the understanding of the MSMS Board that the purchaser constituencies will proceed in the same manner in order for MDHC to produce a complete statewide data base. (Nov89Bd#32.)

2. Advertising Infant Formula to the Public

MSMS agrees with the following position of the American Academy of Pediatrics discouraging the advertising of infant formula products to the public:

"Principles for use in response to companies advertising infant formula directly to the public are as follows:

1. The Academy reaffirms its policy opposing direct advertising of infant formula to the public.

2. If an infant formula company advertises its formula directly to the public, then the Academy will, as soon as practical but in no event later than a year from the date on which the direct advertising commences, terminate support of Academy programs by that company. If the Academy determines that it is necessary or advisable, in support of its policy against the direct advertising of infant formula to the public, the Academy will also terminate support of Academy programs by companies directly or indirectly involved in or otherwise aiding or abetting a joint venture or other endeavor to directly advertise infant formula to the public. If a company does not currently provide support for Academy programs, then the Academy will not solicit or accept funding from such company for any ongoing or future programs.

3. Advertising in Academy publications directed to the professional and exhibiting at Academy meetings will not be impacted by the fact that such company is engaged in direct advertising of infant formula to the public.

4. In response to advertising of infant formula to the public, chapters and individual members must follow their own dictates and make it clear that they are speaking/acting as individual persons or chapters and are not representing the Academy."

3. Endorsement of Practice Recommendations

1. MSMS does not endorse guidelines, recommendations or protocols which prescribe standards of medical practice, unless they are developed by a recognized national medical specialty society or by MSMS, with participation by appropriate medical experts.

2. If a Michigan state government agency perceives a need to develop practice recommendations in response to a pressing public health problem, MSMS will cooperate in the effort through the following measures:

a) MSMS will facilitate contacts with appropriate national specialty societies to determine if practice recommendations already have been developed.

b) If no recommendations are available, MSMS will offer to convene an expert committee, comprised solely of medical experts in the area under review, to develop appropriate recommendations.

c) MSMS will assist in efforts to disseminate the recommendations to physicians and when appropriate, to the public.

3. MSMS will continue to promote physician involvement in state government committees, where physician expertise is needed to assist a state government agency in carrying out statutory responsibilities with respect to the protection of the public health."

Committee on Constitution and Bylaws

Robert H. Evans, MD, Chairman

(This standing committee also serves as the Reference Committee on Constitution and Bylaws.)

The House of Delegates adopted the following Bylaws amendment at its 1989 Annual Meeting, on first reading. It was laid over to the 1990 House of Delegates meeting as prescribed in the Bylaws:

Election of Speaker and Vice Speaker.

Amend the Bylaws, Paragraph 12.60, to read:

"OFFICERS — The officers of the House of Delegates shall be the Speaker and the Vice-Speaker. The Secretary of the Society shall be the Secretary of the House of Delegates. The Speaker and Vice-Speaker shall be elected by the House of Delegates at the Annual Session from the members of the then-constituted House of Delegates." (new language underlined).

COMMENT: This amendment, suggested by the MSMS executive office, clarifies the Bylaws language regarding the customary practice of selecting the Speaker and Vice-Speaker from the House of Delegates.

RECOMMENDATION: That this amendment be adopted on second reading and incorporated in the MSMS Bylaws.

Members of the Committee are: N. Warn Courtney, MD, Kalamazoo; Angel Farina, MD, Wayne; Jack D. Gift, MD, Jackson; Thomas F. Higby, MD, Livingston; Dorothy M. Kahkonen, MD, Wayne; Steven E. Newman, MD, Oakland; William E. Madigan (ex officio) and Richard E. Weber (ex officio).



Members of Reference Committee F consider resolutions concerning medical education.

Committee on Ways and Means

Fred W. Whitehouse, MD, Chairman

The Ways and Means Committee met on January 10 and April 11, with its advisors, B. David Wilson, MD, Chairman of the Finance Committee, Billy Ben Baumann, MD, MSMS Treasurer, and Earl G. Moehn, MD, member of the Finance Committee, to review the MSMS Operating Budget. The Ways and Means Committee is pleased to report that the Board of Directors has been able to operate within the financial projections made to the 1987 House of Delegates for FY 1988 through FY 1990. The Finance Committee anticipates ending FY 1990 with a three-year cumulative deficit of (\$41,163) in the Operating Budget. This is less than 1 percent of the FY 1990 Operating Expense Budget of \$4,944,370, and it is close to the (\$4,640) cumulative deficit for FY 1988 through FY 1990 that was projected in 1987.

Dues Structure

The Ways and Means Committee made the following observations:

1. The last dues raise was \$60, from \$290 to \$350, beginning in FY 1988, with dues remaining fixed at \$350 for FY 1989 and FY 1990.
2. Dues revenue is projected to increase from \$2,950,342 in FY 1988 to \$2,990,000 in FY 1990. This is an increase of 1.34 percent.
3. Non-dues revenue is projected to increase from \$1,486,034 in FY 1988 to \$1,823,575 in FY 1990. This is an increase of 22.7 percent.

The Ways and Means Committee made three projections for the next three years (FY 1991 through FY 1993), assuming different levels of dues income, non-dues revenue, and expenditures:

1. If there is no dues increase, and non-dues income increases at 13% per annum (from base of \$1,865,150) and expenses increase at 10% per annum (from base of \$5,243,775), MSMS will have a cumulative three year deficit of (\$2,278,376) at the end of FY 1993. (See Addendum B)



Members of Reference Committee D consider resolutions concerning professional liability.

2. If there is a one time fixed dues increase of \$85/annum beginning in FY 1991, the cumulative FY 1993 deficit will decrease to (\$143,426). (See Addendum C)
3. If there is a one time fixed dues increase of \$90/annum beginning in FY 1991, the cumulative FY 1993, surplus would be \$13,324. (See Addendum D)

In addition, the Committee using available data made dues comparisons of (1) MSMS to other state medical associations for 1990 and 1991, (See Addendum E) and (2) MSMS, AMA, and selected county society dues for the years 1981 through 1990. (See Addendum F)

The Committee also reviewed an analysis of MSMS dues from 1981 through 1989 based on a 1981 constant dollar. The analysis revealed dues have changed insignificantly over the nine years when expressed in 1981 dollars. (See Addendum G)

The Ways and Means Committee compared and discussed the end results of not raising dues versus raising dues by a fixed \$85 or \$90 per annum for the next three years to avoid an the Operating Fund deficit.

The Committee recognized that certain strategies could be carried out. One would be across the board cuts of a fixed percentage (5-15%). Another strategy would be decreases in targeted expenses, such as CME programs, the Impaired Physicians Program, legislative activity, medical economics, health care delivery, public relations/public service etc. The Committee spent considerable time reviewing these options and concluded that these approaches were not acceptable because the existence of these programs are essential to the effectiveness of MSMS. In order to keep MSMS a viable and actively growing organization, a dues increase for FY 1991-FY 1993 would be preferable to decreasing important activities by whatever strategy.

The Ways and Means Committee concluded that a one time fixed dues increase of \$90 for the next three years is necessary so that MSMS can continue to provide the vital services expected by the membership and to operate at a breakeven level at the end of FY 1993. The Committee further concluded that MSMS should continue with the three-year dues cycles that have worked so well in the past. Therefore, the Committee recommends a \$90 dues increase from \$350 to \$440 beginning FY 1991 with dues remaining fixed at \$440 for FY 1992 and FY 1993.

Special Expense Allowance for Officers

In addition, the Ways and Means Committee, as required by the MSMS Bylaws, reviewed the following recommendations from the Finance Committee for the special expenses allowance for the officers for FY 1990 as follows:

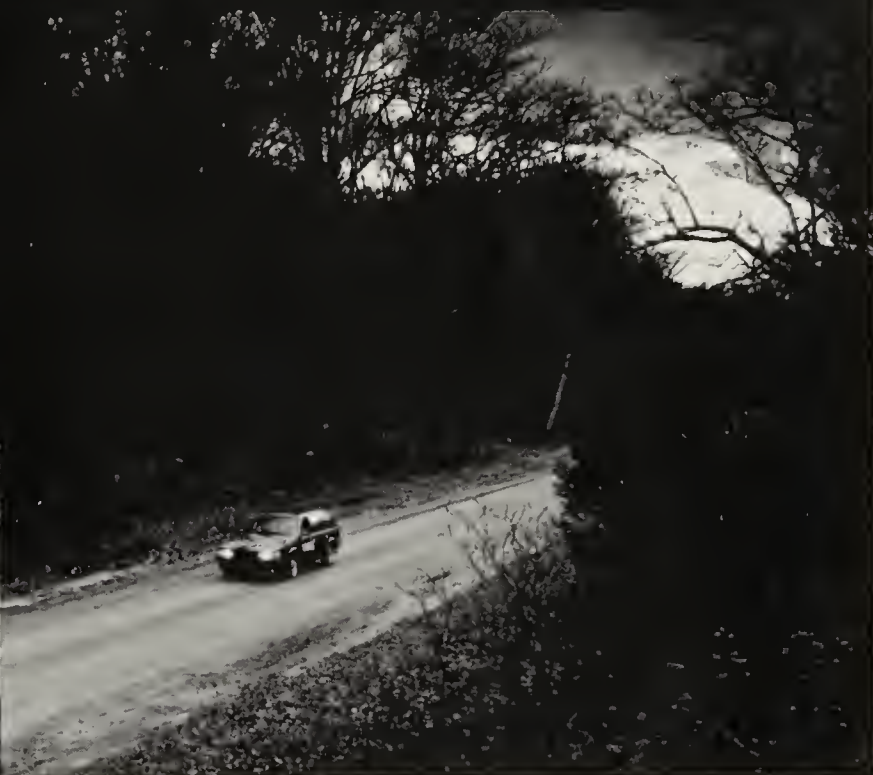
	1990	1989	Increase
President	\$12,000	\$6,000	+ \$6,000
President-elect	4,000	4,000	
Chairman of the Board	5,000	3,500	+ 1,500
Immediate Past President	3,000	2,000	+ 1,000
Speaker of the House	1,000	1,000	
Secretary	1,000	1,000	
Treasurer	2,000	1,000	+ 1,000
	\$28,000	\$18,500	\$9,500

The Committee concluded that these increases were reasonable and long overdue, and approved the recommendation of the Finance Committee.

The Ways and Means Committee will serve as the Reference Committee on Ways and Means at the House of Delegates and will make its final recommendations to the House of Delegates on Sunday, May 6.

Members of the Committee include: Warren E. Bontrager, MD; Arnold L. Brown, MD; Richard P. Heuschele, MD; David M. C. Hislop, MD; Robert C. Prophater, MD; and James K. Watkins, MD.

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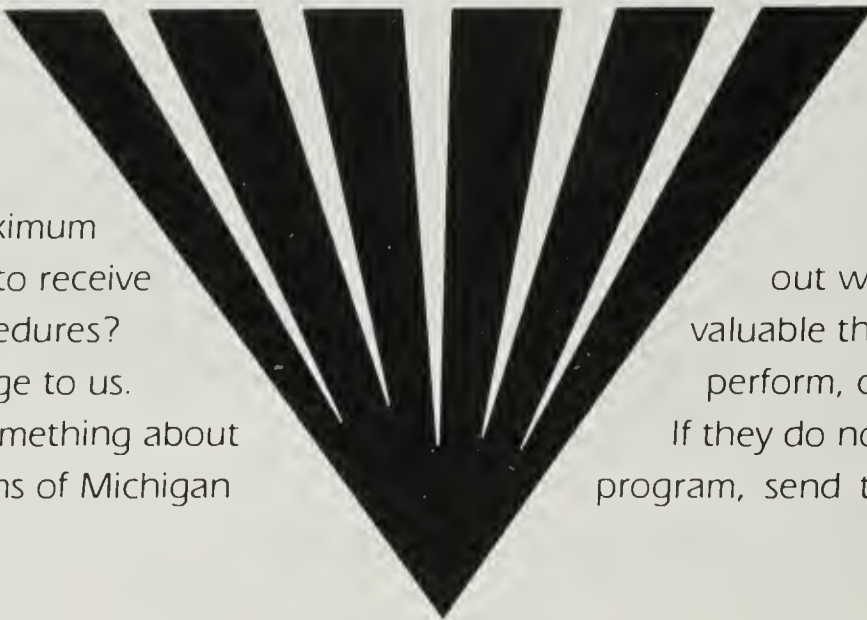
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• 1-90A

Radioactive Waste Disposal.

Allen F. Turcke, MD, Genesee County

Substitute Resolution (in lieu of 1-90A and 2-90A). Adopted.

RESOLVED: That MSMS expeditiously review and make recommendations on the issue of radioactive waste storage, the review to include consideration of at least the following issues:

1. Michigan's participation in the low-level radioactive waste disposal compact;
2. The effects of radioactive waste disposal on Michigan's environment and public health;
3. The need for revisions to the low-level Radioactive Waste Policy Act of 1980 including:
 - a. The need for revision of the definition of high level radioactive waste
 - b. The need for a single, national site for radioactive waste disposal
 - c. The appropriateness of forcing Michigan or any other state to accept ownership of a radioactive waste facility
 - d. The need for appropriate environmental and public health safeguards at radioactive waste facilities
 - e. Indication of who should pay for the maintenance of and liability associated with radioactive waste facilities
4. The need for provision of storage and disposal facilities for radioactive waste generated through medical use.

• 2-90A

In Opposition to the Low-Level Radioactive Waste Policy Act of 1980.

Allen F. Turcke, MD, Genesee County

Substitute Resolution (in lieu of 1-90A and 2-90A). Adopted. See Resolution 1-90A.

• 3-90A

Third Party Imbursement for Physician Services.

Louis E. Sanford, MD, Ionia-Montcalm County

Substitute Resolution (in lieu of 3-90A and 25-90A). Adopted.

RESOLVED: That MSMS work with interested parties to attain a level of imbursement comparable to other regional states from third party payers for physician services.

• 4-90A

Optional Health Care Insurance Coverage for MSMS Members.

Louis E. Sanford, MD, Ionia-Montcalm County

Disapproved.

• 5-90A

Reimbursement for Medical Trauma Care Related to Drug Enforcement.

David A. Milko, MD, Kalamazoo County

No Action.

• 6-90A

Medical Mediation Panels.

Frederick H. Lindenfeld, MD, Berrien County

Adopted as Amended.

RESOLVED: That mediation panels in malpractice cases should not convene unless there are at least two (2) physicians present to serve on the panels in order to maintain a balance of the panel and provide equity to both parties; and be it further

RESOLVED: That the judge or circuit court administrator who is assigned to a malpractice case choose two (2) physicians randomly from the medical specialty, rather than have them chosen by the plaintiff and defense attorneys; and be it further

RESOLVED: That MSMS continue its involvement with the development of rules and procedures for mediation panels for malpractice cases.

• 7-90A

National Practitioner Data Bank

Implementation.

Frederick H. Lindenfeld, MD, Berrien County

Adopted.

RESOLVED: That MSMS adamantly proclaim its opposition to the implementation of the National Practitioner Data Bank.

• 8-90A

Nursing Home Admission Assessment.

David M. Woodliff, MD, Barry County

Adopted.

RESOLVED: That MSMS oppose the passage of House Bills 5363 and 5388 and does everything in its power to prevent passage of these bills.

• 9-90A

Indemnification for Indigent Obstetrical Care.

Edward E. Elder, Jr., MD, Oakland County

Adopted as Amended.

RESOLVED: That MSMS use every legal means possible to have the State of Michigan offer indemnification for medical liability to physicians who care for indigent obstetrical patients.

• 10-90A

Liability Insurance Premium Renewal Notices.

Dean G. Sienko, MD, for the Young Physicians Section

Adopted as Amended.

RESOLVED: That MSMS encourage the Michigan Insurance Commissioner to promulgate rules to demand premium notification to policyholders at least 30 days prior to renewal date for malpractice insurance policies.

• 11-90A

BCBSM Cease Implementation of the Physician Retrospective Profiling Programming.

Krishna K. Sawhney, MD, for the Hospital Medical Staff Section

Disapproved.

• 12-90A

MDPAC Board to Include Graduates of Foreign Medical Schools.

Samir R. Yahia, MD, for the Section for Graduates of Foreign Medical Schools

Disapproved.



Fred R. Severyn, MD, Wayne delegate, speaks out on one of 115 resolutions brought before the House.

• 13-90A

Cataract Survey Pre-Certification.

Timothy B. Aiken, MD, St. Clair County
Disapproved.

• 14-90A

Automobile No-Fault Insurance.

Dean G. Sienko, MD, for the Young Physicians Section

Substitute Resolution (in lieu of 14-90A and 61-90A). Adopted.

RESOLVED: That MSMS oppose the use of the Workers' Compensation fee schedule for auto insurance health care services; and be it further

RESOLVED: That MSMS work to amend Senate Bill 712 and actively pursue patient concerns regarding access and retention of appropriate physician and hospital reimbursement for automobile injuries; and be it further

RESOLVED: That MSMS pursue efforts to address all factors contributing to the high cost of no-fault automobile insurance.

• 15-90A

Managed Care Periodic Interim Payment Programs.

Krishna K. Sawhney, MD, for the Hospital Medical Staff Section

Adopted.

RESOLVED: That MSMS work with the major managed care companies and other third party payors to formalize a system for periodic interim payments for prenatal care.

• 16-90A

Closing of Small Community Hospitals.

Samir R. Yahia, MD, for the Section for Graduates of Foreign Medical Schools

Adopted.

RESOLVED: That MSMS request the AMA to encourage legislation to reduce the financial constraints on small rural hospitals in order to improve access to health care.

• 17-90A

Ophthalmology for the Lower Income Patient.

Edward E. Elder, Jr., MD, Oakland County
Disapproved.

• 18-90A

Physician Testimony is the Practice of Medicine.

Gerald H. Mandell, MD, for the Wayne County Medical Society Delegation

Referred to the Board for further study.



MSMS Board Chairman Frank B. Walker, MD, addresses delegates at the 1990 House of Delegates meeting.

RESOLVED: That MSMS seek legislation that physician witnesses in medical liability cases who are under oath are, in fact, practicing their profession; and be it further

RESOLVED: That MSMS seek legislation to allow the Michigan Board of Medicine to deal with physicians who give false testimony given in medical liability cases by appropriate disciplinary action.

• 19-90A

Adoption.

Dean G. Sienko, MD, for the Young Physicians Section

Adopted as Amended.

RESOLVED: That MSMS request the AMA to support the provision of adoption information as an option to unintended pregnancies; and be it further

RESOLVED: That MSMS request the AMA to support and encourage the counselling of women with unintended pregnancies as to the option of adoption.

• 20-90A

Universal Payment Program for Birth Procedures.

Krishna K. Sawhney, MD, for the Hospital Medical Staff Section

No Action.

• 21-90A

GFMS Members to International Medical Scholar Program.

Samir R. Yahia, MD, for the Section for Graduates of Foreign Medical Schools

Adopted.

RESOLVED: That MSMS request the AMA to appoint at least one graduate of a foreign medical school on the Council of the International Medical Scholar Programs; and be it further

RESOLVED: That this member should keep the AMA Advisory Committee on In-

ternational Medical Graduates informed of all activities.

• 22-90A

Medical Reimbursement.

Edward E. Elder, Jr., MD, Oakland County
Adopted as Amended.

RESOLVED: That MSMS continue to encourage and assist the development of voluntary assignment programs in each county in Michigan for the lower income Medicare patients similar to the Midland County Medical Society Program.

• 23-90A

Clean Air Inside Airplanes.

John F. Fennessey, MD, for the Wayne County Medical Society Delegation

No Action.

• 24-90A

Family Planning as a Basic Health Service.

Dean G. Sienko, MD, for the Young Physicians Section

Substitute Resolution (in lieu of 24-90A and 65-90A). Adopted.

RESOLVED: That MSMS ask the legislature to declare family planning services as a basic health service and encourage the legislature to earmark sufficient funds to support those services.

• 25-90A

Interstate Reimbursement Parity for Obstetrical Services.

Krishna K. Sawhney, MD, for the Hospital Medical Staff Section

Substitute Resolution (in lieu of 3-90A and 25-90A). Adopted. See Resolution 3-90A.

• 26-90A

Michigan as Initial Participant in AMA "National Credentials Verification Service."

Samir R. Yahia, MD, for the Section for Graduates of Foreign Medical Schools
Adopted.

RESOLVED: That MSMS ask the AMA that Michigan be one of the initial states participating in the AMA's "National Credentials Verification Service."

• 27-90A

Conflicting Standards Between Specialty Societies and Michigan Department of Public Health (MDPH).

Bradley T. Barnes, MD, Oakland County
Adopted as Amended.

RESOLVED: That MSMS work with the Michigan Department of Public Health to assure specialty society input when developing regulations for the prevention, detection and treatment of various medical conditions; and be it further

RESOLVED: That MSMS take steps to assure that regulations for the prevention, detection and treatment of various medical conditions are written with sufficient flexibility to permit physicians to practice according to the accepted standards of their specialty organizations.

• 28-90A

Establishment of Tighter Communications Between Prosecutorial and Licensing Agencies and Organized Medicine.

George H. Greidinger, MD, for the Genesee County Medical Society Delegation
Disapproved.

• 29-90A

Managing Stress as a Physician.

Krishna K. Sawhney, MD, for the Wayne County Medical Society Delegation
Adopted as Amended.

RESOLVED: That MSMS work with medical school facilities in Michigan to educate medical students on the management of stress and on other topics, such as exercise and nutrition, not currently included in the medical school curriculum.

• 30-90A

Alternative Methods of Medical Practice.

Dean G. Sienko, MD, for the Young Physicians Section
Adopted as Amended.

RESOLVED: That MSMS ask the AMA to evaluate available literature and report on alternative methods of medical practice such as acupuncture, herbal medicines, etc.; and be it further

RESOLVED: That MSMS continue its opposition to House Bills 4832 and 4833 which would permit the licensure of acupuncturists.

• 31-90A

Systems for Dictated Medical Records in Emergency Departments.

Krishna K. Sawhney, MD, for the Hospital Medical Staff Section
Adopted.

RESOLVED: That MSMS encourage hospitals to provide systems for dictated medical records in their emergency departments.

• 32-90A

Good Samaritan Law Extended to Indigent Care.

Samir R. Yahia, MD, for the Section for Graduates of Foreign Medical Schools
Adopted as Amended.

RESOLVED: That MSMS aggressively pursue passage of legislation to indemnify physicians against malpractice suits arising from the provision of indigent care.

• 33-90A

Clinical Laboratory Improvement Act of 1988.

Bradley T. Barnes, MD, Oakland County
No Action.

• 34-90A

Physicians Professional Responsibility.

Krishna K. Sawhney, MD, for the Wayne County Medical Society Delegation
Adopted.

RESOLVED: That MSMS study what systems or mechanisms are available for Michigan physicians to deal with interprofessional relations, patient practice issues and similar ethical values.

• 35-90A

Cardiopulmonary Resuscitation (CPR).



MSMS President-Elect Susan H. Adelman, MD, addresses delegates.

Dean G. Sienko, MD, for the Young Physicians Section

No Action.

• 36-90A

On-Site Automatic Cardiac Defibrillators and Trained Personnel in Sports Arenas.

Krishna K. Sawhney, MD, for the Hospital Medical Staff Section
Adopted as Amended.

RESOLVED: That MSMS, through educational efforts, encourage large gathering facilities to provide adequate emergency services, including the latest technical medical equipment and trained personnel when feasible.

• 37-90A

Name Change from Graduates of Foreign Medical Schools to International Medical Graduates.

Samir R. Yahia, MD, for the Section for Graduates of Foreign Medical Schools
Adopted.

RESOLVED: That MSMS change the name of the MSMS Section For Graduates of Foreign Medical Schools to the MSMS Section for International Medical Graduates; and be it further

RESOLVED: That the appropriate By-laws changes be made to reflect this change.

• 38-90A

Call Me Physician.

Bradley T. Barnes, MD, Oakland County
Adopted.

RESOLVED: That MSMS encourage its members to request that they be referred to as "physicians" apart from other "providers" in any contracts and documents they are asked to sign.



MSMS Board Chairman Frank B. Walker, MD, left, MSMS President Susan H. Adehnan, MD, middle, and incoming MSMS Board Chairman Jack L. Barry, MD, found many reasons to applaud during the MSMS House of Delegates meeting.

• 39-90A

Promotion of Energy Efficiency to Reduce Pollution.

John F. Fennessey, MD, for the Wayne County Medical Society Delegation

No Action.

• 40-90A

Physician Recruitment in Michigan.

Dean G. Sienko, MD, for the Young Physicians Section

Adopted as Amended.

RESOLVED: That MSMS develop a research project to evaluate established practicing physician flux (non-resident training) into and out of the State of Michigan, as well as other factors in adjacent states; including third party reimbursement, small business taxation, and other barriers which affect physician recruitment and retention in Michigan.

• 41-90A

Interest on Medical Education Tax Deductible.

Krishna K. Sawhney, MD, for the Hospital Medical Staff Section

No Action.

• 42-90A

MSMS Medical Liability Media Campaign.

Edward E. Elder, Jr., MD, Oakland County
Adopted as Amended.

RESOLVED: That MSMS establish a media campaign noting the infrequency of significant injury or death due to medical negligence; and be it further

RESOLVED: That MSMS continue to study alternatives to the tort system.

• 43-90A

Treatment of Chemical Dependency.

John F. Fennessey, MD, for the Wayne County Medical Society Delegation

Substitute Resolution (in lieu of 43-90A and 69-90A). Adopted.

RESOLVED: That MSMS compile complete information about available addiction treatment centers in Michigan, particularly with reference to those able to treat pregnancy women and teenagers; and be it further

RESOLVED: That where gaps in the available addiction treatment network may exist, MSMS encourage the initiation of additional treatment facilities; and be it further

RESOLVED: That MSMS work with the Michigan Office of Substance Abuse Services to make available to physicians on a continuing basis, knowledge concerning the treatment of substance abuse.

• 44-90A

Child Care for Mildly Ill Children.

Dean G. Sienko, MD, for the Young Physicians Section

Adopted as Amended.

RESOLVED: That MSMS seek appointment of a physician to the Department of Social Services Task Force for the Care of Mildly Ill Children in Child Care Centers, who would provide medical care expertise to task force members and Department of Social Services staff; and be it further

RESOLVED: That the MSMS physician representative to the Department of Social Services Task Force for the Care of Mildly Ill Children in Child Care Centers bring back recommendations to the MSMS Board regarding development of licensed child care centers for mildly ill children.

• 45-90A

Studying the Feasibility of State Medical Societies Processing Medical Licensure.

Krishna K. Sawhney, MD, for the Hospital Medical Staff Section

No Action.

• 46-90A

Physicians' Review Organization of Michigan (PROM) Anonymity.

Edward E. Elder, Jr., MD, Oakland County
Disapproved.

• 47-90A

Environmental Health Care Committee.

Dean G. Sienko, MD, for the Young Physicians Section

Adopted.

RESOLVED: That MSMS form an environmental health committee to provide input to state and federal departments and to act as advisory force to the environmental health care issues that affect our Michigan communities.

• 48-90A

National Competency Exams for Emigrants Having Professional Health Care Education and Training to Expedite the Obtainment of Visas and Employment.

Krishna K. Sawhney, MD, for the Hospital Medical Staff Section

Disapproved.

• 49-90A

Access to Medical Care for the Poor.

Edward E. Elder, Jr., MD, for the Oakland County Medical Society Delegation

Adopted as Amended.

RESOLVED: That MSMS seek ways to indemnify physicians and hospitals from medical liability when they consent to treat patients in a charitable setting; and be it further

RESOLVED: That MSMS seek ways to have the State of Michigan or alternative agencies cover medical liability for all Medicaid patients.

• 50-90A

Medicaid Obstetric and Pediatric Services: Michigan's Noncompliance with Federal Regulations.

Edward E. Elder, Jr., MD, Oakland County
Adopted as Amended.

RESOLVED: That MSMS continue to explore the feasibility of legal action against the state Medicaid program for failure to provide sufficient access to obstetric and pediatric services, as required by federal law, by taking steps to document the extent to which obstetric and pediatric services are not accessible to Medicaid recipients; and be it further

RESOLVED: That MSMS review and, as necessary, help revise the Michigan Department of Social Service's plan for data collection demonstrating compliance with the Omnibus Reconciliation Act of 1989.

• 51-90A

Term of Office for AMA Positions.

John F. Fennessey, MD, for the Wayne County Medical Society Delegation

Adopted.

RESOLVED: That MSMS request the AMA Board of Trustees to review the terms of office for AMA councils, the maximum number of terms permitted, as well as whether councils are elected or appointed; and be it further

RESOLVED: That MSMS request the AMA Board of Trustees to recommend changes in current rules and policies which will promote revitalization of the AMA, with broadened opportunities in the house and in leadership positions for younger and more diverse segments of the physician community.

• 52-90A

Delay in Health Care Facility and Technology Development.

Dean G. Sienko, MD, for the Young Physicians Section

Adopted as Amended.

RESOLVED: That MSMS seek changes that will expedite architecture and engineering review and fire marshall approval for health facility and technology construction projects, without jeopardizing the safety or quality of the projects.

• 53-90A

National Practitioner Data Bank.

Krishna K. Sawhney, MD, for the Hospital Medical Staff Section

Substitute Resolution (in lieu of 53-90A, 72-90A and 73-90A).

Adopted.

RESOLVED: That MSMS request that the AMA work with the Congress to eliminate the inclusion of malpractice data in the National Practitioner Data Bank; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to seek definition of "under investigation" as used in the Health Care Quality Improvement Act of 1986.

• 54-90A

A New BCBSM Contract.

Edward E. Elder, Jr., MD, Oakland County

No Action.

• 55-90A

Expiration Dates on Medications.

Orlando Sison, MD, for the Wayne County Medical Society Delegation

Adopted as Amended.

RESOLVED: That MSMS work with the Michigan Board of Pharmacy to require its pharmacists to indicate dispensing and expiration dates on all prescribed medication labels to help patients avoid misusing prescribed drugs.

• 56-90A

BCBSM Pre-Admission Approvals.

Dean G. Sienko, MD, for the Young Physicians Section

Adopted as Amended.

RESOLVED: That MSMS seek all avenues to prevent retrospective payment denials of pre-approved health care services delivered to BCBSM subscribers by Michigan physicians.

• 57-90A

Development of a List of Physician Volunteers.

Krishna K. Sawhney, MD, for the Hospital Medical Staff Section

Adopted as Amended.

RESOLVED: That MSMS request the AMA to explore the possibility and feasibility of developing a list of credentialed physician volunteers who can be available at a short notice to travel and provide help in an area of disaster when called upon.

• 58-90A

Fair Fees for Chart Copying.

Robert S. Levine, MD, Oakland County

Disapproved.

• 59-90A

Physician's Pharmacy Licensing Fee.

John F. Fennessey, MD, for the Wayne County Medical Society Delegation

Adopted.

RESOLVED: That MSMS vigorously oppose the physician pharmacy license fee in Michigan.

• 60-90A

Recycling and Using Recycled Paper.

Dean G. Sienko, MD, for the Young Physicians Section

Adopted as Amended.

RESOLVED: That MSMS recycle, rather than discard, paper whenever possible; and be it further

RESOLVED: That MSMS offices purchase and use recycled paper to the greatest extent possible; and be it further

RESOLVED: That MSMS demonstrate its concern on this issue by placing a 'recycled paper' logo at the bottom of such stationary.



Busharat Ahmad, MD, Chairman of the MSMS Section for International Medical Graduates, listens intently to testimony given at the MSMS House of Delegates meeting.

• 61-90A

Automobile No-Fault.

Krishna K. Sawhney, MD, for the Hospital Medical Staff Section

Substitute Resolution (in lieu of 14-90A and 61-90A).

See Resolution 14-90A.

• 62-90A

Health Insurance Consultation Service.

Robert S. Levine, MD, Oakland County

Adopted as Amended.

RESOLVED: That MSMS request Physician Service Group to study the feasibility of developing a consulting service, on a fee for service basis, for the business owner seeking impartial objective information about health insurance plans; and be it further

RESOLVED: That MSMS develop an information package which physicians could give to their patients seeking information about various health plans.

• 63-90A

Recertification of State License.

John F. Fennessey, MD, for the Wayne County Medical Society Delegation

No Action.

• 64-90A

Resident Hours.

Krishna K. Sawhney, MD, for the Hospital Medical Staff Section

Adopted as Amended.

RESOLVED: That MSMS continue to work with the Accreditation Council for Graduate Medical Education and Residency Review Committees to develop more humane residency work hours and continue to oppose any legislative regulation.

• 65-90A

Family Planning.

David M. C. Hislop, MD, St. Clair County

Substitute Resolution (in lieu of 24-90A and 65-90A). See Substitute Resolution 24-90A.

• 66-90A

Opposition to Specialty Recertification Tied to State Licensure.

John F. Fennessey, MD, for the Wayne County Medical Society Delegation

Adopted.

RESOLVED: That MSMS oppose any proposal whereby a physician's license will not be renewed because he or she has not been recertified in his or her specialty.

• 67-90A

Care for Underserved Areas.

Krishna K. Sawhney, MD, for the Hospital Medical Staff Section

Adopted as Amended.

RESOLVED: That MSMS monitor the implementation of Public Act 16 of 1990, which establishes a school loan repayment program for certain health professionals and a grant program for health professional students, to assure appropriate designation of medically underserved areas by the Michigan Department of Public Health.

• 68-90A

Family Planning.

David M. C. Hislop, MD, St. Clair County

Disapproved.

• 69-90A

Update Treatment for Substance Abuse.

Gerald H. Mandell, MD, for the Wayne County Medical Society Delegation

Substitute Resolution (in lieu of 43-90A and 69-90A). See Substitute Resolution 43-90A.

• 70-90A

IRS Reclassification of CME Cost.

Krishna K. Sawhney, MD, for the Hospital Medical Staff Section

Disapproved.

• 71-90A

Medicaid Reimbursement.

John C. Sullivan, MD, St. Clair County

No Action.

• 72-90A

Opposition to Malpractice Information in the National Practitioner Data Bank.

John F. Fennessey, MD, for the Wayne

County Medical Society Delegation

Substitute Resolution (in lieu of 53-90A, 72-90A and 73-90A). See Substitute Resolution 53-90A.

• 73-90A

National Practitioner Data Bank.

Krishna K. Sawhney, MD, for the Hospital Medical Staff Section

Substitute Resolution (in lieu of 53-90A, 72-90A and 73-90A). See Substitute Resolution 53-90A.

• 74-90A

Certificate of Need Regulation.

Timothy B. Aiken, MD, St. Clair County

Disapproved.

• 75-90A

The Need for Adequate Time to Review the First Revision in Forty Years of the BCBSM Provider Contract.

Allen F. Turcke, MD, for the Genesee County Medical Society Delegation

No Action.

• 76-90A

Clinical Care Guidelines.

Dorothy M. Kahkonen, MD, and Fred W. Whitehouse, MD, for the Wayne County Medical Society Delegation

Adopted as Amended.

RESOLVED: That MSMS support the implementation of guidelines developed by recognized national medical specialty societies to enhance state-of-the-art quality care for patients; and be it further

RESOLVED: That MSMS encourage its membership to use these clinical guidelines as a means of providing quality care to their patients.

• 77-90A

Oppose Omnibus Budget Reconciliation Act (OBRA 1989) Ruling.

Edmund M. Barbour, MD, for the Wayne County Medical Society Delegation

No Action.

• 78-90A

Unclaimed Bodies as Potential Tissue and Organ Donors.

Mark D. Kolins, MD, for the Wayne County Medical Society Delegation

Referred to Board for further action.

RESOLVED: That MSMS seek to have legislation introduced which would give initial authority over unclaimed bodies to the local medical examiner in order to give timely permission for tissue and organ donation.

• 79-90A

Discontinue Unnecessary Time Records for the Michigan Society of Pathologists.

Edwin M. Knights, MD, for the Michigan Society of Pathologists

Adopted as Amended.

RESOLVED: That MSMS ask the AMA to request the Health Care Financing Administration (HCFA) to discontinue quarterly time study reports by pathologists in hospitals.

• 80-90A

Duplicate Bureaucratic Regulations.

Gerald H. Mandell, MD, for the Wayne County Medical Society Delegation

Adopted.

RESOLVED: That MSMS lend its resources to identifying duplicate regulatory activities and inspection so that these matters may be brought to the attention of our legislators, governor and regulatory agencies; and be it further

RESOLVED: That MSMS request the AMA to lend its resources to identifying duplicate regulatory activities and inspection so that these matters may be brought to the attention of our legislators, governor and regulatory agencies; and be it further

RESOLVED: That such information be made available nationally via the AMA in an attempt to eliminate duplicate bureaucratic bodies and unnecessary regulations.

• 81-90A

Excessive Medical Administrative Costs.

Gerald H. Mandell, MD, for the Wayne County Medical Society Delegation

Adopted.

RESOLVED: That MSMS actively seek reduction in regulatory requirements such as record review, length of stay review, insurance requirements and form completion, and diagnosis coding for physicians and hospitals; and be it further

RESOLVED: That MSMS request the AMA to actively seek reduction in regulatory requirements such as record review, length of stay, insurance requirements and form completion, and diagnosis coding for physicians and hospitals; and be it further

RESOLVED: That MSMS and the AMA vigorously oppose future regulatory requirements for physicians and hospitals that are not compensated.

• 82-90A

National Practitioner Data Bank.

Gerald H. Mandell, MD, for the Wayne County Medical Society Delegation
Adopted.

RESOLVED: That MSMS request the AMA to vigorously oppose the mandated requirements of using the National Practitioner Data Bank for reappointments to a medical staff; and be it further

RESOLVED: That MSMS request the AMA to continue to oppose the use of such mandated requirement because the data available is virtually useless in the re-appointment process and the cost is, therefore, unnecessary and burdensome; and be it further

RESOLVED: That MSMS request the AMA to continue to oppose mandated re-appointment inquiry because there is no reimbursement for such costs.

• 83-90A

Modifications in the Arbitration Law.

Arthur A. Ulmer, MD, for the Wayne County Medical Society Delegation

Adopted as Amended.

RESOLVED: That MSMS promote the following modifications in the arbitration law:

1. Annual automatic renewal of arbitration contract between the patient and physician, and
2. The contract would remain in force as long as a relationship exists between the physician and his patient or until revoked by either on 60 day notice, and
3. Modify the physician/patient agreement so it is valid in all settings where health care is provided, and
4. Sixty days following a patients death, the arbitration agreement becomes irrevocable.

• 84-90A

Litigation of Non-Meritorious Suits.

Arthur A. Ulmer, MD, for the Wayne County Medical Society Delegation

Adopted as Amended.

RESOLVED: That MSMS request the liability insurance carriers to investigate a mechanism to supplement the insured physician's liability policy limits in cases where the insurance company desires to litigate.

• 85-90A

Insurance Premiums.

Arthur A. Ulmer, MD, for the Wayne County Medical Society Delegation

Adopted as Amended.

RESOLVED: That MSMS request the liability insurance carriers to investigate a more equitable insurance premium struc-

ture that can vary with a physician's volume of practice.

• 86-90A

Adjustment of Jury Verdicts for Patients Contributory Negligence.

Arthur A. Ulmer, MD, for the Wayne County Medical Society Delegation

No Action.

• 87-90A

Cost of Medical Waste Disposal.

Gerald H. Mandell, MD, for the Wayne County Medical Society Delegation

Adopted as Amended.

RESOLVED: That MSMS, in conjunction with the Michigan Hospital Association, provide data to our legislators and our Governor concerning the cost of medical waste disposal programs; and be it further

RESOLVED: That MSMS insist upon reimbursement from the State for the costs incurred by physicians to implement medical waste disposal programs.

• 88-90A

Medicaid Denial Review.

Gerald H. Mandell, MD, for the Wayne County Medical Society Delegation

Adopted as Amended.

RESOLVED: That MSMS aggressively pursue the adoption by Medicaid of a less restrictive and onerous denial rate for hospitals (at least five percent) before requiring 100 percent case review.

• 89-90A

Shortage of Nursing Home Beds.

Charles R. Schmitter, Jr., MD, Washtenaw County

Adopted as Amended.

RESOLVED: That MSMS pursue legislative and administrative avenues, including the appointment of a physician to the Michigan Department of Public Health Advisory Committee on Long Term Nursing Bed Needs, to resolve the shortage of basic and skilled nursing home beds.

• 90-90A

Directory of Graduate Medical Education Programs.

Pino D. Colone, for the Medical Student Section

Adopted as Amended.

RESOLVED: That MSMS encourage the AMA to continue to provide the Directory of Graduate Medical Education Program (DGMEP) to medical students until the transition to the AMA-Fellowship and

Residency Electronic and Interactive Database Access (FREIDA) system is complete; and be it further

RESOLVED: That MSMS encourage the AMA to make the FREIDA system compatible with Apple/Macintosh computers; and be it further

RESOLVED: That MSMS research the feasibility of obtaining the FREIDA system for distribution to medical students, and use as a membership incentive for the student non-member.

• 91-90A

Immunization and Preventative Health Care for Children.

John F. Fennessey, MD, for the Wayne County Medical Society Delegation

Adopted as Amended.

RESOLVED: That MSMS seek legislation to provide coverage for preventative health care visits and immunization for all children.

• 92-90A

Endorsement of a Living Will.

Siarosh Varjavandi, MD, for the Genesee County Medical Society Delegation

Adopted as Amended.

RESOLVED: That MSMS make available to its membership the Genesee County Medical Society's format for a Living Will/Durable Power of Attorney document with the understanding that no assurance of legal validity can be given; and be it further

RESOLVED: That MSMS continue to work for passage of Living Will/Durable Power of Attorney legislation by the Michigan Legislature.

• 93-90A

Initiative to Clarify State and Federal Regulations Which Affect Michigan Physicians.

AppaRao Mukkamala, MD, for the Genesee County Medical Society Delegation

No Action.

• 94-90A

Forward Planning for Medicine.

Allan C. D. Brown, MD, and Krishna K. Sawhney, MD, Wayne County

Adopted.

RESOLVED: That MSMS constitute a standing committee (Think Tank) charged with the contingency planning of viable responses to possible future changes with a time horizon of not less than three years; and be it further

RESOLVED: That MSMS ask the AMA to constitute a standing committee

(Think Tank) charged with the contingency planning of viable responses to possible future changes with a time horizon of not less than three years.

• 95-90A

Needs of Dementia Patients in Michigan.

Dawn E. Springer, MD, Ingham County, for Margaret Z. Jones, MD

Adopted as Amended.

RESOLVED: That MSMS support funding for the implementation of Public Act 441, 442, and 443 of 1988, which establish diagnostic and assessment services, a registry and a post-mortem examination program aimed at meeting the needs of patients with dementia and their families.

• 96-90A

GFMS Participation in Organized Medicine.

Samir R. Yahia, MD, for the Section for Graduates of Foreign Medical Schools

No Action.

• 97-90A

Filling of Available Residency Spots.

Samir R. Yahia, MD, for the Section for Graduates of Foreign Medical Schools

No Action.

• 98-90A

Foreign Medical Graduate Examination in Medical Sciences (FMGEMS) Scores Not Sole Criteria for Residency Selection.

Samir R. Yahia, MD, for the Section for Graduates of Foreign Medical Schools

Adopted.

RESOLVED: That MSMS working with the AMA urge that Foreign Medical Graduate Examination in Medical Sciences (FMGEMS) scores not be used as the sole criteria for selecting interns and residents; and be it further

RESOLVED: That MSMS working with the AMA recommend that residency programs consider all the candidates' attributes and qualifications during the selection process.

• 99-90A

GFMS Representation on Residency Selection Committees.

Samir R. Yahia, MD, for the Section for Graduates of Foreign Medical Schools

Adopted as Amended.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to recommend to the ACGME and its



Delegates applauded the actions taken by the House at the May 4-6 meeting in Grand Rapids.

Residency Review Committees (RRC) that they encourage appropriate representation by graduates of foreign medical schools on residency selection committees.

• 100-90A

Inclusion of Residency Interview Costs in the Financial Aid of Fourth Year Medical Students.

Laurence Trueman, Medical Student Section, for Peter Toth, WSU

Adopted as Amended.

RESOLVED: That MSMS request the AMA to work with the Department of Education to reverse policy and allow students to use Title IV (loan) funds to meet the expenses of residency interviews; or, if this policy cannot be reversed, that MSMS request the AMA to seek legislation so that the costs for residency interviews may be included in the financial aid for which fourth year medical students may apply.

• 101-90A

Sharing the Financial and Manpower Burden of the Human Genome Project with Other Nations.

Laurence Trueman, Medical Student Section, for Peter Toth, WSU

Adopted as Amended.

RESOLVED: That MSMS request the AMA to seek methods of encouraging industrialized nations interested in the results of the Human Genome Project to: (a) Help to coordinate international research efforts in this area, and (b) Assist in the development of a data bank through which the scientists of nations participating in the project may access and distribute new information.

• 102-90A

Medical School Financial Aid Reforms.

Laurence Trueman, Medical Student Section, for Peter Toth, WSU

Adopted.

RESOLVED: That MSMS request the AMA to clarify the real need to many medical students in obtaining levels of financial aid from the state and federal government that are commensurate with the true cost of pursuing a medical education full-time; and be it further

RESOLVED: That MSMS request the AMA to seek an increase in the annual borrowing limit of the Stafford loan from \$7,500 to \$10,000 and increase current funding levels of the Perkins loan program, and provide larger grant and scholarship funds to which students who demonstrate exceptional levels of need may apply; and be it further

RESOLVED: That MSMS request the AMA to seek from the banking industry a sliding rate of interest on accumulated debt, for individuals obtaining a medical education loan.

• 103-90A

GFMS Section Representation for Resident Physicians.

Samir R. Yahia, MD, for the Section for Graduates of Foreign Medical Schools

Adopted.

RESOLVED: That MSMS change the bylaws of its Section for Graduates of Foreign Medical Schools to allow for representation from the MSMS Section for Resident Physicians in the form of two delegates who are graduates of international medical schools from the Resident Section to the GFMS Section, to be elected annually.

• 104-90A

MSMS Involvement in Workers' Compensation.

Virgilio Villarreal, MD, Genesee County

Substitute Resolution (in lieu of 104-90A and 106-90A). Adopted.

RESOLVED: That MSMS continue to provide input on Workers' Compensation fee schedules and dispute resolution to the state legislature and the Michigan Department of Labor; and be it further

RESOLVED: That MSMS work to achieve a Workers' Compensation reimbursement rate which is equitable.

• 105-90A

GFMS Section Representation for Non-Hospital Affiliated Physicians.

Samir R. Yahia, MD, for the Section for Graduates of Foreign Medical Schools

Adopted.

RESOLVED: That MSMS amend the bylaws of its Sections for Graduates of Foreign Medical Schools to allow for two delegates to be elected to the Section delegate body by a special annual vote of MSMS members who are graduates of foreign medical schools and who are not hospital-affiliated.

• 106-90A

MSMS Increased Involvement in Worker Compensation Fee Schedules.

Virgilio Villarreal, MD, Genesee County

Substitute Resolution (in lieu of 104-90A and 106-90A). See Substitute Resolution 104-90A.

• 107-90A

Eliminate Worker's Compensation Medical Fee Schedule.

Robert A. Holmes, MD, and Omero Iung, MD, Ingham County for Floyd G. Goodman, MD

Not Accepted as a Late Resolution.

• 108-90A

Eliminate the Use of Government Mandated Medical Fee Schedules.

Robert A. Holmes, MD, and Omero Iung, MD, Ingham County, for Floyd G. Goodman, MD

Not Accepted as a Late Resolution.

• 109-90A

Legislation re BCBSM Health Insurance Programs.

Robert A. Holmes, MD, and Omero Iung, MD, Ingham County, for Floyd G. Goodman, MD

Not Accepted as a Late Resolution.

• 110-90A

Legislation to Guarantee the BCBSM Gives Physicians Due Process.

Robert A. Holmes, MD, and Omero Iung, MD, Ingham County, for Floyd G. Goodman, MD

Not Accepted as a Late Resolution.

• 111-90A

Audit of BCBSM.

Robert A. Holmes, MD, and Omero Iung, MD, Ingham County, for Floyd G. Goodman, MD

Not Accepted as a Late Resolution.

• 112-90A

Commercial Advertising by Trial Attorneys that Heightens the Liability Crisis in Michigan.

Robert C. Packer, MD, Muskegon County

No Action.

• 113-90A

Encourage Showing of the Auxiliary Medical Liability Videotape.

Robert C. Packer, MD, Muskegon County

Adopted.

RESOLVED: That MSMS encourage county medical societies to unite in regional coalitions, and enlist the support of area hospitals so that they may approach local media in an attempt to gain publicity of the material included in the malpractice videotape and other factual information as it relates to the medical malpractice crisis in Michigan.

• 114-90A

Support of Charles C. Vincent, MD.

Robert S. Levine, MD, Oakland County

Adopted as Amended.

RESOLVED: That the MSMS House of Delegates indicate their support of Charles C. Vincent, MD, in his bid for a seat in the US House of Representatives; and be it further

RESOLVED: That this House allow Charles C. Vincent, MD, to indicate on his literature that he has the support of MDPAC; and be it further

RESOLVED: That we indicate our appreciation to MDPAC for its strong support of the candidacy of Charles C. Vincent, MD.

• 115-90A

Surgical Assistants.

Jaime V. Aragones, MD, Oakland County

Adopted.

RESOLVED: That MSMS take the position that surgical assistants play a vital role in the delivery of quality medical care; and be it further

RESOLVED: That MSMS, in conjunction with the American College of Surgeons, seek proper representation with Medicare explaining these concerns which are of paramount importance to the welfare and protection of the public; and be it further

RESOLVED: That MSMS request the AMA to oppose such regulatory mandates that interfere with the delivery of quality medical care.

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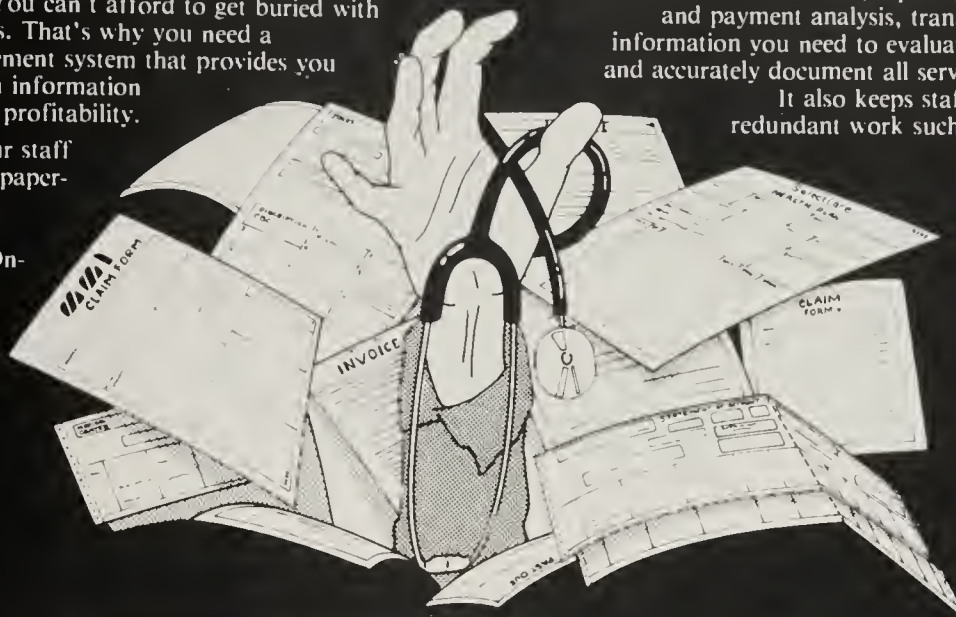
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Members who have maintained an active membership in good standing for 25 years in any one or more constituent state societies of the American Medical Association with any five years in Michigan.

Allegan – A. Peter Brachman, MD; Janis Pone, MD

Berrien – Henry J. Klos, MD

Calhoun – L. Harold Caviness, MD; Graham F. Colquhoun, MD; Gerald S. O'Sullivan, MD

Genesee – Arthur L. Tuuri, MD

Grand Traverse-Leelanau-Benzie – John G. Milliken, MD; Jack E. Weih, MD

Hillsdale – Carl A. Peterson, MD

Ingham – L. George Suhrlund, MD

Iosco-Arenac – Norman P. Payea, MD; William F. Kutsche, MD

Kalamazoo – George D. Alger, MD

Kent – Paul VanPortfliet, MD

Lenawee – Howard R. Eddy, MD

Monroe – Walter A. Meier, MD

Oakland – Charles G. Barone, MD; Roy V. Cooley, MD; James L. Frey, MD

Shiawassee – John F. MacGregor, MD

Van Buren – Adelbert L. Staff, MD

Washtenaw – Thomas N. Cross, MD; Robert C. Hendrix, MD

Wexford-Missaukee – Arno A. Whipple, MD

Wayne – James E. Beard, MD; Ernest M. Berkas, MD; Manuel Bouza, MD; Gerald M. Breneman, MD; Ruth B. Campbell, MD; Norman E. Clarke, Jr., MD; George N. Ferris, MD; Sylvia Griva-Lizlovs, MD; Richard H. Hall, MD; Reginald W. F. Harnett, MD; Muriel B. Harris, MD; Milton C. Hoffman, MD; Glen A. Johnston, MD; Alhert J. Kaspor, MD; Eugene J. Kochkodan, MD

RETIRED MEMBERSHIPS

Members who have maintained membership for 5 years in the component medical society and retired from active practice.

Alpena-Alcona-Presque Isle – Ellsworth R. Littler, MD

Barry – Thomas W. Myers, MD

Bay – William A. DeYoung, MD; Walter L. Howland, MD; Leo B. McSherry, MD

Calhoun – Marcelo C. Canlas, MD

Grand Traverse-Leelanau-Benzie – Oswald V. Clark, MD; Arthur F. Dundon, MD; G. Edward Stokes, MD; Philip K. Wiley, MD

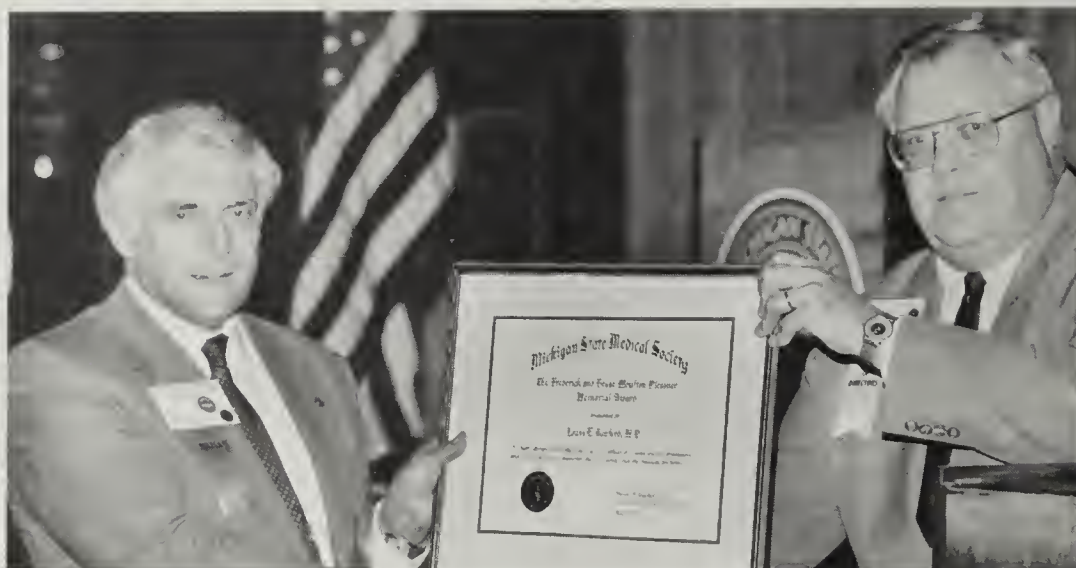
Ingham – Harry D. Allis, MD; Joseph A. Caruso, MD; D. Bonta Hiscoe, MD; Genevieve G. Howen, MD; Richard S. Johnson, MD; Richard K. Meinke, MD; Robert S. Ort, MD; Ronald C. Peets, MD; Donald R. Quigley, MD; Carolyn M. Texera, MD; Robert F. Thimmig, MD; Garson H. Tishkoff, MD

Ionia-Montcalm – Charles E. Stevens, MD

Jackson – Robert J. Kobs, MD

Kalamazoo – Bruce L. Brown, MD; Jose L. Campos, MD; Norman A. Gremel, MD; James W. Loynd, II, MD; Donald G. May, MD; James W. Scholl, MD

Kent – Gerald F. Barofsky, MD; Frederick S. Gillett, MD; William E. Kincaid, MD; Bernard P. Kool, MD; James P. Muldoon, MD; Howard F. Postma, MD; Robert H. Puite, MD; William F. Reus, MD; William O. VandenBerg, MD



MSMS Board Chairman Frank B. Walker, MD, congratulates Louis E. Sanford, MD, recipient of the Plessner Memorial Award. The award is given to a physician who "best exemplifies the practice and ethics of a rural country practitioner..."

Lapeer – Harry R. Zemmer, MD

Lenawee – Maurice M. Galliani, MD; Mualla Kaynak, MD; Xenophon Skufis, MD

Macomb – Dieter Wendling, MD; Alex Zotovas, MD
Marquette-Alger – Janice A. Lindstrom, MD; Fred C. Sabin, MD; K. Charles Wright, MD

Midland – Robert T. Blackhurst, MD

Muskegon – Ralph F. Askam, MD; Kshitish C. Das, MD; Sachiko K. Okamoto, MD

Newaygo – Alicia A. Pedelty, MD

Northern Michigan – William A. Dawson, MD

Oakland – Peter D. Atchoo, MD; Quentin P. Hamilton, MD; Nanette J. Jagnow, MD; James T. Mimura, MD; Donna L. Opie, MD; Thomas J. Sansone, MD; George R. Sewell, MD; Warren E. Sheldon, MD; John Silvani, MD; King L. Tan, MD; Seymour A. Vander, MD; Jay J. VanZoeren, MD

Saginaw – Laurence Bruggers, MD; Clyde P. Davenport, MD; George A. Ellis, MD; Victor L. Hill, MD; Min H. Kim, MD; H. F. Labson, MD

Shiawassee – Alfred W. Foerster, MD

Tuscola – Edward J. Miles, MD

Washtenaw – John B. Atwater, MD; Howard S. Caukin, MD; Robert T. Hartman, MD; Seong J. Kim, MD; Beverly C. Payne, MD

Wayne – Thomas M. Batchelor, MD; Allen Berlin, MD; Bruce K. Lemon, MD; Karl J. Merkle, MD; Kathryn L. O'Connor, MD; Lawrence A. Pratt, MD; Frank P. Raiford, III, MD; Donald C. Ross, MD; John M. Shuey, MD; Robert F. Sly, MD; Richard H. Smith, MD; Algert L. Steinhach, MD; Bruce T. Wheatley, MD; Lawrence H. Krohn, MD; Raymond S. Kurtzman, MD; Eugene H. Lansing, MD; Frank J. Malje, MD; Vincent J. Marecki, MD; J. Martin Miller, MD; Donald L. Otto, MD; Frank P. Prokop, MD; Paul Rizzo, MD; Joseph J. Rowe, MD; Guy W. Sewell, MD; Edwin G. Snoke, MD; Harry Tarpinian, MD; Roberto I. Valdesuso, MD; Rudolf E. Wilhelm, MD; Joseph J. Woods, MD; Leonard S. Zuhroff, MD

Plessner Award

This award, presented to the physician who best exemplifies the practice and ethics of a rural country practitioner, was presented by Chairman of the Board, Frank B. Walker, MD, to:

Louis E. Sanford, MD, Belding, MI

Fifty-Year Awards

Fifty-year awards were presented to the following:

Gerald D. Adamian, MD, Southfield, MI
D. Hess Anderson, MD, Portland, MI
Harley H. Anderson, MD, Long Lake, MI
Harold E. Anderson, MD, Battle Creek, MI
William J. Arnold, MD, Detroit, MI
John H. Bailey, MD
Stuart P. Barden, MD, Rockport, TX
Benjamin Barenholtz, MD, Southfield, MI
John G. Barker, MD, Troy, MI
John C. Benson, MD, Key West, FL
Fredk. E. Bentley, MD, Northville, MI
Donald J. Birmingham, MD, Grosse Pte. Woods, MI
Gertrude K. Black, MD, Williamston, MI
Ralph Blocksma, MD, Grand Rapids, MI
John L. Boccaccio, MD, Grosse Pte. Shores, MI
Robert E. Bogue, MD, Bellaire, MI
T. Boyd Bolitho, MD, New Bern, NC
Richard C. Brown, MD, Owosso, MI
Henry C. Bryant, MD, Ann Arbor, MI
Robert C. Buehrig, MD, Clarkston, MI
Eugene T. Capuzzi, MD, Indian River, MI
Jacob L. Chason, MD, Bloomfield Hills, MI
Robert P. Clifford, MD, St. Clair, MI
Lawrence A. Comstock, MD, Trenton, MI
Paul J. Connolly, MD, Cedarville, MI
Maurice M. Croll, MD, Farmington Hills, MI
Harold E. Cross, MD, Grosse Pointe, MI
Doris E. Dahlstrom, MD, Hickory Corners, MI
Justo R. De Varona, MD, Cassopolis, MI
Clyde K. Dryer, MD, Wayne, MI
Elmer P. Ellias, MD, Miami Beach, FL
Eldon W. Erickson, MD, Lincoln Park, MI
Virginia M. Ferrara, MD, Birmingham, MI
John R. Franck, MD, Ironwood, MI
S. Phillip Grillo, MD, Belleville, MI
Robert M. Heavenrich, MD, Saginaw, MI
Mildred L. Herkner, MD, Lake Leelanau, MI
John T. Herwick, MD, Farmington Hills, MI
Samuel P. Hicks, MD, Ann Arbor, MI
Glenn I. Hiller, MD, Southfield, MI
Richard J. Hunt, MD, Sarasota, FL
Thomas D. Johnson, MD, Walled Lake, MI
John L. Kitzmiller, MD, St. Joseph, MI
Louise E. Kozlow, MD, Fountain Hills, AZ



Twenty-eight Michigan physicians were presented an award for 50 years of service.

John D. Langston, MD, Dallas, TX
 Donald F. Larkin, MD, Waterville, ME
 Joseph R. Lentini, MD, Grand Rapids, MI
 Frederick H. Lindenfeld, MD, Niles, MI
 Aleksandrs Lusis, MD, Ann Arbor, MI
 M. A. MacDonald, MD, Kalamazoo, MI
 Max W. Mattes, MD, Southfield, MI
 Roscoe I. McFadden, MD, Leesburg, FL
 Sidney Miller, MD, Bloomfield Hills, MI
 Anthony J. Miltich, MD, Roscommon, MI
 Martyna Miskinis, MD, Detroit, MI
 Stephen K. Molnar, MD, Gregory, MI
 Joseph R. Montante, MD, Spring Hill, FL
 Raymond W. Monto, MD, Lathrup Village, MI
 Willard B. Morell, MD, Midland, MI
 Leonard J. Morgrette, MD, Saginaw, MI
 Nathan D. Munro, MD, Jackson, MI
 Darwin M. Nelson, MD, Pentwater, MI
 C. W. Newton, Jr., MD, Ann Arbor, MI
 Joseph I. Nosanchuk, MD, Sterling Heights, MI
 Donald E. O'Brien, MD, Ironwood, MI
 Seymour L. Osher, MD, Flint, MI
 Donald J. Pearson, MD, Battle Creek, MI
 Walter E. Pelczar, MD, Hendersonville, NC
 John M. Pandy, MD, St. Clair Shores, MI
 Donald G. Pike, MD, Traverse City, MI
 Edward Y. Postma, MD, Grand Rapids, MI
 Julien Priver, MD, San Diego, CA
 Alex Procailo, MD
 Naim M. Raby, MD, Southgate, MI
 Frederick W. Rau, MD, Murphy, NC
 Benjamin Reder, MD, Southfield, MI
 Samuel G. Reisman, MD, Bloomfield Hills, MI
 Robert G. Rice, MD, East Lansing, MI
 Harry L. Riggs, MD, Pontiac, MI
 Charles S. Robb, MD, Ada, MI
 Ivan J. Roggen, MD, Saginaw, MI
 Joseph J. Ruva, MD, Venice, FL
 Vincent J. Sadovsky, MD, Sun City West, AZ
 Joseph N. Schaeffer, MD, Sault Ste. Marie, MI
 Maxwell L. Shadley, MD, Pontiac, MI
 Hyman D. Shapiro, MD, Naples, FL
 Richard H. Sidell, MD, Grand Rapids, MI
 Jack A. Sill, MD, Birmingham, MI
 Russell T. Smith, MD
 John W. Strayer, MD, Niles, MI
 Walter A. Stryker, MD, Wyandotte, MI
 Leland L. Swenson, MD, North Muskegon, MI

Frank D. Thompson, MD, East Grand Rapids, MI
 Donald G. Trapp, MD, Beulah, MI
 Robert H. Trimby, MD, East Lansing, MI
 Fredk I. Van Wagnen, MD, Clark Lake, MI
 Bernice K. Warren, MD, Bradenton, FL
 Henry E. Wiechowski, MD, Detroit, MI
 Morton J. Wiener, MD, Highland Beach, FL
 Edward J. Zabinski, MD, Detroit, MI
 Margaret H. Zolen, MD, Schoolcraft, MI

Flag Awards

This award, was presented to the following presidents of a statewide non-medical organization:

Jose Goldman, MD, President, American Diabetes Association, Michigan Affiliate, Detroit, MI
 Sheikh M. Saeed, MD, President, Michigan Association of Blood Banks, Detroit, MI

National Presidents Awards

This award, was presented to the following for their service as presidents of national medical organizations:

Howard A. Brody, MD, President, Society of Human Health Values, East Lansing, MI
 William J. Fry, MD, President, Society of Vascular Surgery, Ann Arbor, MI

Presidential Citation

This award, presented to physicians or lay persons who have made an outstanding contribution to medicine in the state, was presented to:

Charles C. Vincent, MD, Detroit, MI

AMA House of Delegates Certificate of Appreciation

This award, presented to physicians for their past service on the Michigan Delegation to the American Medical Association, was presented to:

Richard H. Gascoigne, MD, Adrian, MI

Elections

The House of Delegates elected the following MSMS officers, directors and delegates and alternates to the American Medical Association.

Officers (to 1991 Annual Session)

President Susan Hershberg Adelman, MD, Southfield

President-elect Robert D. Burton, MD, Grand Rapids

Secretary Thomas R. Berglund, MD, Portage

Treasurer Billy Ben Baumann, MD, Pontiac

Speaker Robert D. Allaben, MD, Detroit

Vice-Speaker . . Gary D. Maynard, MD, Kalamazoo

Assistant Secretary . Justin L. Sleight, MD, Lansing

Assistant Treasurer . B. David Wilson, MD, Kalamazoo

Directors (to 1993 Annual Session)

First District Robert W. Black, MD, Detroit

First District W. Peter McCabe, MD, Grosse Pointe Woods

First District Krishna Sawhney, MD, Taylor

Seventh District David M.C. Hislop, MD, Port Huron

Eight District Jack L. Barry, MD, Bay City

Tenth District James L. Fenton, MD, Bay City

Twelfth District Carl F. Hammerstrom, MD, Marquette

Fourteenth District Fred E. Patterson, MD, Jackson

Fifteenth District Peter A. Duhamel, MD, Rochester

Delegates to the American Medical Association (to 1992 Annual Session)

Busharat Ahmad, MD, Marquette

Robert D. Allaben, MD, Detroit

Billy Ben Baumann, MD, Pontiac

Richard L. Rapport, MD, Flint

Louis R. Zako, MD, Dearborn heights

Alternate Delegates to the American Medical Association (to 1992 Annual Session in order of seniority)

Rhoda M. Powsner, MD, Ann Arbor

B. David Wilson, MD, Kalamazoo

Charles C. Vincent, MD, Detroit

John W. Hall, MD, Petoseky

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Donald K. Crandall, MD
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M. Joseph Bowler, MD, Kalamazoo
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MI Society of Anesthesiologists
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Charles C. Vincent, MD

AMA Delegation Advisors:

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Marguerite Shearer, MD

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American College of OB/GYN
Timothy D. Oliver, MD, Shiawassee

Charles R. Schmitter, Jr., MD, Washtenaw
Dawn E. Springer, MD, Ingham

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Thomas E. Stone, MD

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Louis R. Zako, MD

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Kenneth H. Musson, MD, Grand Traverse
Ali H. Sawaf, MD, Delta
Laurence W. Trueman, MD, WSU Student
Michael A. Wozny, MD, Calhoun

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Brian F. Jewell, MD
Gerald H. Mandell, MD

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Chairman
R. Paul Clodfelder, MD, Kent
Margaret E. Gustafson, MD, Mason
AppaRao Mukkamala, MD, Genesee
Mark Sawka, MD, Resident Section
Allen Silbergleit, MD,
MI Soc. of Thoracic and Cardiovascular Surg.
Robert J. Sokol, MD

Board Advisors:

James L. Fenton, MD
Carl F. Hammerstrom, MD
David J. Millard, MD

AMA Delegation Advisors:

Busharat Ahmad, MD
Carl A. Gagliardi, MD
Karen VanderWall

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Diana M. Rothman, MD, Washtenaw

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Jack D. Gift, MD, Jackson
Thomas F. Higby, MD, Livingston
Dorothy M. Kahkonen, MD, Wayne
Steven E. Newman, MD, Oakland

Ex officio Members:

William E. Madigan
Richard E. Weber

AMA Delegation Advisor:

Robert D. Allaben, MD

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Chairman
Peter Aliferis, MD, Alpena
John F. Cotant, MD, Wayne
Dennis E. Van Alst, MD, Wexford-Missaukee
David M. Woodliff, MD, Barry

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Warren E. Bontrager, MD, North Central
Arnold L. Brown, MD, Oakland
Richard P. Heuschele, MD, Saginaw
David M. C. Hislop, MD, St. Clair
Robert C. Prophater, MD, Bay
James K. Watkins, MD, Kent

Board Advisors:

Billy Ben Baumann, MD
Earl G. Moehn, MD
B. David Wilson, MD

Delegates' Record of Attendance

May 4-6

	MEETING								
	1st	2nd	3rd						
OFFICERS				LEELANAU-BENZIE:				Richard H. Gascoigne, MD	- - -
Speaker:				Lawrence S. Loesel, MD	X	X	X	Marinus Van Ooyen, MD	- - -
Robert D. Burton, MD	X	X	X	Kenneth H. Musson, MD	X	X	X	Inad Haddad, MD	X X X
Vice-Speaker:				Edward J. Rutkowski, MD	X	X	X	LIVINGSTON:	
Robert D. Allaben, MD	X	X	X	GRATIOT:				Thomas F. Highby, MD	- - -
Secretary:				Ashok R. Sonnad, MD	X	X	-	LUCE:	
Thomas R. Berglund, MD	X	X	X	HILLSDALE:				Steven A. Myers, MD	- - -
DELEGATES AND				Lucio O. Saygan, MD	-	-	-	MACOMB:	
ALTERNATES				HOUGHTON-BARAGA-				James B. Anderson, MD	- - -
ALLEGAN:				KEWEENAW:				Ben R. Fajardo, MD	- - -
Not Represented				Kenneth E. Rowe, MD	X	X	X	Paul R. Gradolph, MD	- X X
ALPENA-ALCONA-				HURON:				Joel M. Kriegel, MD	X X X
PRESQUE-ISLE:				Edward E. Steinhardt, MD	X	X	-	Byung S. Lee, MD	X X X
Peter Aliferis, MD	X	X	-	INGHAM:				Samir M. Ragheb, MD	X X X
BARRY:				Rolland E. Bethards, MD	X	X	-	Richard A. Stone, MD	X X X
David M. Woodliff, MD	X	X	X	Clyde R. Flory, MD	X	X	X	David S. Weingarden, MD	- - -
BAY:				Robert A. Holmes, MD	X	X	X	Prabhakar N. Reddy, MD	- - X
B. L. Pederson, MD	X	X	-	Omero S. Iung, MD	X	X	X	Akemi Takekoshi, MD	X X X
Robert C. Prophater, MD	-	-	-	David K. Johnson, MD	-	-	-	MANISTEE:	
James F. Stoddard, MD	X	X	-	Martin F. Jones, MD	X	-	-	Vickers C. Hansen, MD	X X -
BERRIEN:				Mitchell A. Rinek, MD	X	X	X	MARQUETTE-ALGER:	
Frank H. Bunker, MD	-	-	-	Dawn E. Springer, MD	X	X	X	Busharat Ahmad, MD	- X X
Frederick H. Lindenfeld, MD	-	X	X	George D. Stilwill, MD	X	X	X	Randall M. Johnson, MD	X X X
Gene E. Maddock, MD	-	X	X	IONIA-MONTCALM:				MASON:	
William C. Bock, MD	X	X	X	Louis E. Sanford, MD	X	X	-	Margaret E. Gustafson, MD	- - -
BRANCH:				IOSCO-ARENAC:				MECOSTA-OSCEOLA-LAKE:	
Donald Paarlberg, MD	-	-	-	Devendra K. Sharma, MD	-	-	-	Frederick C. Guenther, MD	- - -
CALHOUN:				ISABELLA-CLARE:				MENOMINEE:	
B. Douglas Campbell, MD	X	X	X	John M. Caldwell, MD	-	-	-	Herman R. Brukardt, MD	- - -
Robert W. Oakes, MD	X	X	X	JACKSON:				MIDLAND:	
Paul A. Walk, MD	X	X	X	Jack D. Gift, MD	-	X	X	Roy M. Goethe, MD	- - -
Michael A. Wozny, MD	X	X	X	Bruce F. Knoll, MD	-	X	X	Thomas E. Lipps, MD	X X X
CASS:				Parviz Samii, MD	-	-	-	Gary S. Smith, MD	X - X
Boonchoo Chang, MD	X	X	X	KALAMAZOO:				Winifred A. Oyen, MD	X X X
CHIPPEWA-MACKINAC:				E. Joseph Alberding, MD	-	X	X	MONROE:	
Jaak M. Pahn, MD	X	-	-	Owen M. Berow, MD	X	X	X	David J. Lieberman, MD	X X X
CLINTON:				M. Joseph Bowler, MD	X	X	-	Anthony E. Melonakos, MD	- - -
James M. Grost, MD	-	-	-	N. Warn Courtney, MD	-	-	-	S. R. Nair, MD	- X -
DELTA:				David C. Dunstone, MD	X	X	X	MUSKEGON:	
Ali H. Sawaf, MD	-	-	-	Richard T. Jefson, MD	-	-	-	Stephen E. Fisher, MD	- - -
DICKINSON-IRON:				Robert C. Kettunen, MD	X	X	X	Dick L. Kamps, MD	- - -
Not Represented				Gary D. Maynard, MD	X	X	X	Rodney L. Mirich, MD	- - -
EATON:				David A. Milko, MD	X	X	X	Robert C. Packer, MD	- X X
Sherman W. Horn, II, MD	X	X	X	Geoffrey A. Wardwell, MD	-	-	-	A. James Potter, MD	X X X
GENESEE:				James B. Kilway, MD	X	X	-	NEWAYGO:	
Ali A. Esfahani, MD	-	-	-	W. Mark Todd, MD	X	X	-	James D. Webb, MD	X X X
Cyrus Farrehi, MD	-	-	-	KENT:				NORTH CENTRAL:	
George Greidinger, MD	-	-	-	Peter B. App, MD	-	-	-	Warren E. Bontrager, MD	X X X
Vivian M. Lewis, MD	X	X	X	John H. Beernink, MD	X	-	-	NORTHERN MICHIGAN:	
AppaRao Mukkamala, MD	X	-	-	Robert D. Burton, MD	X	X	X	Reed K. Freidinger, MD	X X X
W. Archibald Piper, MD	-	-	X	R. Paul Clodfelder, MD	X	X	X	Russell F. LaBeau, Jr., MD	- - -
Charles A. Thompson, MD	-	-	-	Domenic R. Federico, MD	X	X	X	OAKLAND:	
Allen F. Turcke, MD	-	-	X	Paul O. Farr, MD	X	X	X	Jaime V. Aragones, MD	X X X
Siavosh Varjavandi, MD	-	X	-	Robert H. Hydrick, MD	X	X	-	John V. Balian, MD	- - -
Virgilio G. Villarreal, MD	-	X	X	John M. MacKeigan, MD	X	X	X	Bradley T. Barnes, MD	X X -
Edwin H. Gullekson, MD	X	X	X	Ralph W. Ortwig, MD	-	-	-	Edward E. Barton, MD	X X -
Sudarsan Misra, MD	-	X	X	John P. Papp, MD	X	X	X	Steven S. Bolton, MD	- - -
Willys F. Mueller, Jr., MD	X	X	X	Sarla Puri, MD	-	X	X	Arnold L. Brown, MD	X X X
Richard L. Rapport, MD	-	X	X	John C. Rienstra, MD	X	X	X	Neldagae S. Chisa, MD	- - -
Robert M. Soderstrom, MD	X	-	-	Jack L. Romenca, MD	X	-	X	Nitin C. Doshi, MD	X X X
GOGEBIC:				Joseph A. Sentkeresty, MD	-	-	-	Edward E. Elder, Jr., MD	X X X
Not Represented				Peter D. VanVliet, MD	X	X	X	William S. Floyd, MD	- - -
GRAND TRAVERSE-				James K. Watkins, MD	X	X	X	Michael S. Garcia, MD	- - -
				James R. Irwin, MD	X	X	X	George R. Gerber, MD	X - -
				Ann M. Minnema, MD	-	-	X	Kenneth W. Gitlin, MD	- - -
				LAPEER:				Harvey W. Halberstadt, MD	- - -
				Merle B. Haney, MD	-	X	-	Shamsul M. Haque, MD	- X X
				LENAAWEE:					

Kamalesh Lahiri, MD	-	-	-	Joseph M. Beals, MD	X	X	-	PAST PRESIDENT:			
Bruce T. Lessien, MD	-	-	-	John G. Bielawski, MD	-	-	-	Fred W. Bryant, MD	-	-	-
Robert S. Levine, MD	X	X	X	David H. Blinkhorn, MD	-	-	-	MEDICAL SCHOOL			
Thomas K. Mathew, MD	-	X	-	R. John Bradfield, MD	-	-	-	DEANS:			
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Peter T. Muller, MD	X	X	-	Matthew L. Burman, MD	X	X	-	Joseph E. Johnson, III, MD	-	-	-
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James A. Read, MD	X	-	-	Ned I. Chalat, MD	-	-	-	Michigan State University:			
Joseph L. Schirle, Jr., MD	X	-	-	Julius V. Combs, MD	-	-	-	William Abbett, PhD	-	-	-
Armen Shekerjian, MD	X	-	-	John F. Cotant, MD	X	-	X				
Marvin L. Starman, MD	-	-	-	Jerry Drake, MD	-	-	-	HOSPITAL MEDICAL			
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Quentin P. Hamilton, MD	X	X	-	Riad N. Farah, MD	-	-	-				
Rick E. Olson, MD	X	X	-	Angel Farina, MD	X	-	X	MEDICAL STUDENT			
Panayotis C. Pesaros, MD	X	X	-	John F. Fennessey, MD	X	X	X	SECTION			
Sherry L. Viola, MD	X	X	-	Vincent J. Gallant, MD	-	X	X	UNIVERSITY OF			
OCEANA:				Thomas Ganos, MD	-	-	-	MICHIGAN:			
V. Dale Barker, MD	-	-	-	Alma R. George, MD	-	-	-	Bret R. Gerber	-	-	-
ONTONAGON:				Eric Hanson, MD	-	-	-	MICHIGAN STATE			
James P. Strong, MD	-	-	-	Reginald W. Harnett, MD	X	X	X	UNIVERSITY:			
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William D. Doeblor, MD	X	X	X	Andrew J. Hopkins, MD	-	-	-	WAYNE STATE			
Arnold R. Dood, MD	X	X	X	Fikry F. Ibrahim, MD	-	-	-	UNIVERSITY:			
M. Gary Robertson, MD	X	X	X	John R. Ingall, MD	-	-	-	Laurence W. Trueman	X	-	X
SAGINAW:				Franklin R. Jackson, MD	-	-	-				
Leroy C. Barry, MD	X	X	X	Jitender K. Jain, MD	-	-	-	RESIDENT PHYSICIAN			
Richard C. Hausler, MD	X	X	X	James K. Johnson, MD	-	-	-	SECTION			
Richard P. Heuschele, MD	-	-	X	Dorothy M. Kahkonen, MD	X	X	X	Mark W. Sawka, MD	X	X	X
Ronald L. Jensen, MD	-	-	-	Charles Kessler, MD	-	-	-				
Charles E. Mueller, MD	-	X	-	Ratnaker K. Kini, MD	-	-	-	YOUNG PHYSICIANS			
Thomas A. Egleston, MD	-	-	X	George A. Kling, MD	-	-	-	SECTION			
Jacob C. Ninan, MD	X	X	X	Mark D. Kolins, MD	-	X	-	Dean G. Sienko, MD	X	X	X
Caroline C. Scott, MD	-	X	-	Edward G. Larsen, MD	-	-	-				
ST. CLAIR:				Monroe S. Lechner, MD	X	X	X	SECTION FOR			
Timothy B. Aiken, MD	-	X	-	Robert P. Lilly, MD	X	X	X	GRADUATES OF FOREIGN			
David M. C. Hislop, MD	X	X	X	Gerald H. Mandell, MD	X	X	X	MEDICAL SCHOOLS			
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Robert H. Evans, MD	X	X	X	Joseph R. Oldford, MD	X	X	X				
SANILAC:				Harold Perry, MD	-	X	X	SPECIALTY SOCIETY			
Duane E. Smith, MD	X	X	X	Sol D. Pickard, MD	-	-	-	ORGANIZATIONS			
SCHOOLCRAFT:				Joseph L. Posch, MD	-	-	-	MI ALLERGY SOCIETY:			
Not Represented				Russel F. Proud, MD	X	X	-	James H. Saker, MD	-	-	-
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Timothy D. Oliver, MD	-	X	-	Foster K. Redding, MD	X	X	-	MI SOCIETY OF			
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Alfonso C. Ferreira, MD	X	X	X	Ivan C. Schatten, MD	-	-	-	William B. Jensen, MD	X	X	X
VAN BUREN:				A. William Shafer, MD	-	-	-	MI CHAPTER-AMERICAN			
Michael J. Parks, MD	X	-	-	Yvan J. Silva, MD	-	-	-	COLLEGE OF CHEST			
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Carl M. Frye, MD	X	X	X	Robert A. Songe, MD	-	-	-	MI SOCIETY OF COLON &			
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Dean S. Louis, MD	-	-	-	Arthur A. Ulmer, MD	X	X	X	James A. Surrell, MD	-	-	-
Manfred Marcus, MD	X	X	X	Leonard F. Van Raaphorst,	-	-	-	MI DERMATOLOGICAL			
John E. McGillicuddy, MD	-	-	-	MD	-	-	-	SOCIETY:			
Melvin J. Reinhart, MD	-	-	-	Jay Victor, MD	-	-	-	Thomas D. Harris, MD	-	-	X
Diana M. Rothman, MD	X	X	X	Fred W. Whitehouse, MD	X	X	X	MI CHAPTER-AMERICAN			
Charles R. Schmitter, Jr.,				Bernard J. Woodley, MD	X	X	X	COLLEGE			
MD	X	X	X	Louis R. Zako, MD	-	-	-	OF EMERGENCY			
Douglas B. Siders, MD	-	-	-	Filiberto Cavazos, MD	X	-	-	PHYSICIANS:			
Michael W. Smith, MD	X	X	X	Martin H. Daitch, MD	X	X	X	Michael J. Peikert, MD	-	-	-
Carl Van Appledorn, MD	-	-	-	Fred W. Fitzpatrick, MD	X	-	-	MI ACADEMY OF FAMILY			
Allen C. D. Brown, MD	X	X	X	Robert A. Gerisch, MD	X	-	-	PHYSICIANS:			
WAYNE:				Samuel D. Indenbaum, MD	X	X	X	Robert J. Toteff, MD	X	X	X
Elie D. Aboulafia, MD	-	-	-	Thomas A. McDonald, MD	X	X	X	MI			
Robert D. Allaben, MD	X	X	X	Fred R. Severyn, MD	-	X	X	SOCIETY-GASTROINTESTINAL			
Hassan Amirikia, MD	X	X	X	Narinder K. Sherma, MD	X	X	X	ENDOSCOPY:			
Howard B. Appelman, MD	-	-	-	Joan C. Stryker, MD	X	X	-	Not Represented			
Donald C. Austin, MD	-	-	-	Samir R. Yahia, MD	-	-	X	MI SOCIETY OF			
Edmund M. Barbour, MD	-	-	-					GENERAL SURGEONS:			
				WEXFORD-MISSAUKEE:				Donald C. Camp, MD	X	-	-
				Dennis E. Van Alst, MD	X	X	X	MI HEALTH OFFICERS			
				MEMBERS-AT-LARGE				ASSOCIATION:			
				IMMEDIATE							

Edwin L. Larkin, MD	-	-	-
MI SOCIETY OF INFECTIOUS DISEASE:			
Daniel Havlichek, MD	-	-	-
David B. Martin, MD	X	X	X
MI SOCIETY OF INTERNAL MEDICINE:			
John P. Papp, MD	X	X	X
MI ASSOCIATION OF NEUROLOGICAL SURGEONS:			
Not Represented			
MI NEUROLOGICAL ASSOCIATION:			
Not Represented			
MI COLLEGE OF NUCLEAR PHYSICIANS:			
Not Represented			
MI SECTION-AMERICAN COLLEGE OF OBSTETRICS & GYNECOLOGY:			
James G. Kornmesser, MD	-	-	-
MI OCCUPATIONAL MEDICAL ASSOCIATION:			
Leonard S. Zubroff, MD	-	-	-
MI OPHTHALMOLOGICAL SOCIETY:			
Paul P. Fecko, MD	-	-	-
MI ORTHOPAEDIC SOCIETY:			
Kenneth S. Merriman, MD	X	X	X
MI OTO-LARYNGOLOGICAL SOCIETY:			
Stanley E. Dudek, MD	X	X	X
MI SOCIETY OF PATHOLOGISTS:			
Edwin M. Knights, Jr., MD	X	X	X
MI CHAPTER-AMERICAN ACADEMY OF PEDIATRICS:			
Not Represented			
MI SECTION ON CLINICAL PHARMACOLOGY & THERAPEUTICS:			
John R. Luderer, MD	-	-	-
MI CHAPTER-AMERICAN COLLEGE OF PHYSICIANS:			
Not Represented			
MI ACADEMY OF PHYSICAL MEDICINE & REHABILITATION:			
Sherry L. Viola, MD	X	X	-
MI ACADEMY OF PLASTIC SURGEONS:			
John H. Beernink, MD	X	-	-
MI PSYCHIATRIC SOCIETY:			
Max Gardner, MD	X	X	X
MI PSYCHOANALYTIC SOCIETY:			
Cassandra M. Klyman, MD	-	-	-
MI RADIOLOGICAL SOCIETY:			
Not Represented			
MI CHAPTER-AMERICAN COLLEGE OF SURGEONS:			
Robert D. Allaben, MD	X	X	X
MI SOCIETY OF THERAPEUTIC RADIOLOGISTS:			
Not Represented			
MI SOCIETY OF THORACIC AND CARDIOVASCULAR SURGEONS:			
Allen Silbergleit, MD	X	X	-
MI THORACIC SOCIETY:			
Not Represented	-	-	-
MI UROLOGY SOCIETY:			
Farid Jano, MD	X	X	X

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MEETINGS

MSMS Meetings

September

14,15, MSMS/PSG, AMA's Starting Yourself in Medical Practice: Selecting an HMO or Private Practice, Hyatt Regency, Dearborn, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

18, MSMS Leadership Conference, Radisson Hotel, Lansing, MI. Contact: Mary Anne Ford, Chief, State Government Affairs (517) 337-1351.

19, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

October

3, MSMS/PSG, Health Law Update, Hyatt Regency, Dearborn, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

3,4, MSMS/PSG, Third Party Reimbursement, (3rd) - Hyatt Regency, Dearborn, MI. (4th) - Amway Grand, Grand Rapids, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

9,10,11, MSMS/BCBS Medicare, (9th) - Amway Grand, Grand Rapids, MI. (10th) - To be announced, Bay City, MI. (11th) - Weber Inn, Ann Arbor, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

17,18, MSMS/PSG, Retirement Planning, (17th) - Hyatt Regency, Dearborn, MI. (18th) -

Amway Grand, Grand Rapids, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

23,24,25, MSMS/PSG, Advanced Coding, (23rd) - Dearborn Inn, Dearborn, MI. (24th) - To be announced, Lansing, MI. (25th) - Bay Valley Inn, Bay City, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

31, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

November

6-8, MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, MI. Contact: Sherry L. Fent, Chief, Physician Education (517) 337-1351.

13-16, MSMS/PSG/AMA, Office Staff Training, Hyatt Regency, Dearborn, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

AMA Meetings

October

11-12, Ninth Annual AMA Science Reporters Conference. Contact: John Hammarley (312) 645-4417.

December

2-5, AMA House of Delegates Interim Meeting, Orlando. Contact: Judy Marr, Man-

ager, MSMS Department of Communications and Professional Relations (517) 337-1351.

Michigan Specialty Society Meetings

September

13, Michigan Psychoanalytic Society, Psychoanalysis and Psychotherapy: A Contemporary Perspective. Contact: John J. Hartman, Chairman (313) 559-5855 or (313) 557-8633.

October

11,18,25, Michigan Psychoanalytic Institute Discussion Series for Parents: Mid-Childhood. Contact: Michigan Psychoanalytic Institute, Extension Division (313) 559-5855.

25, Michigan Psychoanalytic Society, Freud and Canard Ferdinand-Meyer. Contact: John J. Hartman, Chairman (313) 559-5855 or (313) 557-8633.

November

8,15,29, Michigan Psychoanalytic Institute Discussion Series for Parents: Adolescence. Contact: Michigan Psychoanalytic Institute, Extension Division (313) 559-5855.

17, Michigan Psychoanalytic Society, Sixteenth Annual Symposium: Perversion and Object Relations; Sexual Misuse of Persons. Contact: John J. Hartman, Chairman (313) 559-5855 or (313) 557-8633.

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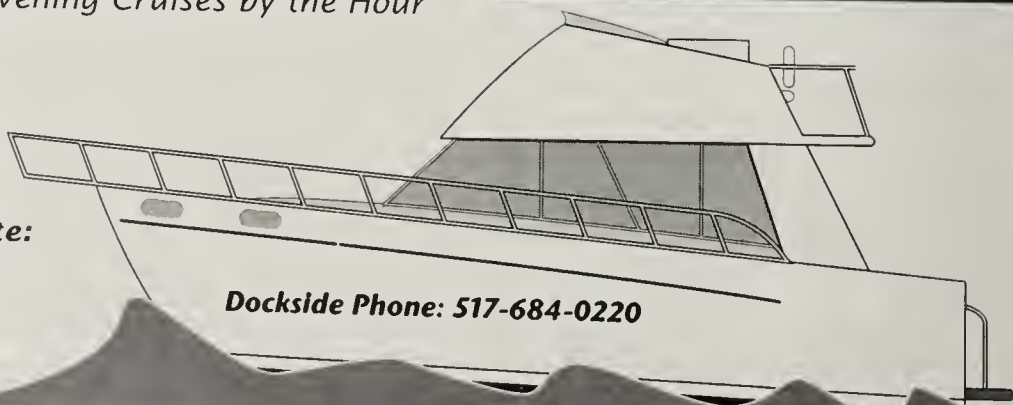
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MEETINGS

National Specialty Society Meetings

August

17-19, American Academy of Family Physicians: National Conference of Family Practice Residents and Students. Kansas City, MO. Contact: Beth Paulsen, Manager (800) 274-2237, ext. 4420.

September

9-13, American Academy of Otolaryngology - Head and Neck Surgery - Annual Meeting. San Diego, CA. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

16-19, American College of Emergency Physicians - Annual Meeting. San Francisco, CA. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

21-23, Society of Thoracic Surgeons: Interim Meeting. Chicago, IL. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

21-26, American College of Radiology: Annual Meeting. Nashville, TN. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

October

5-10, American Academy of Pediatrics: Annual Scientific Meeting. Boston, MA. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

6-8, American Academy of Family Physicians: Congress of Delegates. Dallas, TX.

Contact: Beth Paulsen, Manager (800) 274-2237 ext. 4220.

7-11, American Academy of Family Physicians: Scientific Assembly. Dallas, TX. Contact: Beth Paulsen, Manager (800) 274-2237 ext. 4220.

7-12, American College of Surgeons: Annual Clinical Congress. San Francisco, CA. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

8-11, American Academy of Family Physicians: Annual Meeting. Dallas TX. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

20-25, Congress of Neurological Surgeons: Annual Meeting. Los Angeles, CA. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

20-26, College of American Pathologists: Annual Fall Meeting. Dallas, TX. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

21-26, American Society of Plastic and Reconstructive Surgeons: Annual Meeting. Boston, MA. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

26-28, American College of Utilization Review Physicians: 1990 National Seminar. San Francisco, CA. Contact: Janelle Miller, Executive Director (813) 497-3340.

26-31, American College of Gastroenterology: Annual Scientific Meeting. San Francisco, CA. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

November

15-17, American Society of Abdominal Surgeons: Interim Meeting. Tampa, FL. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

Other Meetings

August

18-24, Ninth Annual Meeting of The Society of Magnetic Resonance in Medicine. Contact: SMRM, 1918 University Ave., Suite 3C, Berkeley, CA 94704. (415) 841-1899.

September

24-25, Fifth Annual Urological Postgraduate Course. Contact: Ananias C. Diokno, MD, William Beaumont Hospital. (313) 288-2554.



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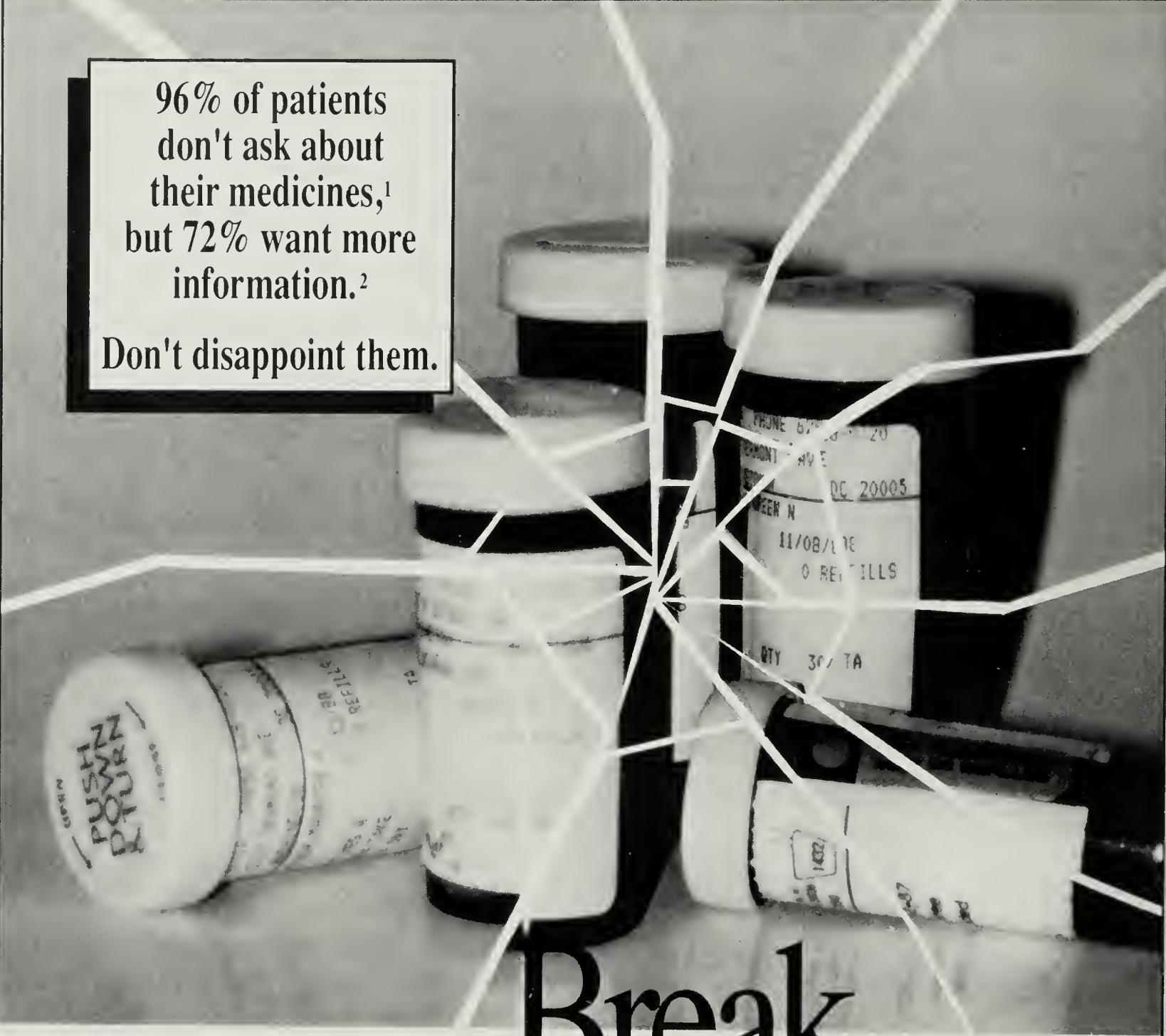
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¹ FDA survey, "Patient Receipt of Rx Drug Information", 1983

² A Study of Attitudes, Concerns, and Information Needs for Rx Drugs
and Related Illnesses, CBS Television Network Consumer Model Survey, 1983

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

August

14-16, MALPH Fifth Annual Conference: "Public Health Partnerships...Winning Teams." Location: Mission Point Resort, Mackinac Island, Michigan. Sponsor: Michigan Association for Local Public Health. Contact: Julie Zdybel, 215 N. Walnut, P. O. Box 14065, Lansing, MI 48901. (517) 485-0660. Approved for: 3 hours Category I Credit.

16-18, Fourth Annual Contemporary Issues in Obstetrics and Gynecology. Location: Grand Traverse Resort, Traverse City, Michigan. Sponsor: University of Michigan Medical School and Northwestern University Medical School. Contact: Julie Jacobs, Registrar, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 936-9800. Approved for: 13 hours Category I Credit.

17-18, Endoscopic Sinus Surgery. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Otolaryngology-Head and Neck Surgery. Contact: Teresa Mitchell, Program Assistant, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. Approved for: 15 hours Category I Credit.

19-22, Internal Medicine Update. Location: Grand Hotel, Mackinac Island, Michigan. Sponsor: University of Michigan Medical School, Department of Internal Medicine. Contact: Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. Approved for: 11 hours Category I Credit.

24-26, 1st Annual Anesthesiology Sym-

posium. Location: Ritz-Carlton Hotel, Dearborn, Michigan. Sponsor: Henry Ford Hospital, Office of Medical Education. Contact: Shelley L. Helton, Office of Continuing Medical Education, 2799 West Grand Boulevard, Detroit, MI 48202-2689. (313) 876-3073. Approved for: 17 hours Category I Credit.

September

12, New Developments in the Care of AIDS Patients. Location: Henry Ford Hospital – E & R Bldg. #2055, Detroit Michigan. Sponsor: Henry Ford Hospital, Office of Medical Education. Contact: Shelley L. Helton, Office of Continuing Medical Education, 2799 West Grand Boulevard, Detroit, MI 48202-2689. (313) 876-3073. Approved for: 4.25 hours Category I Credit.

21-22, Recent Advances in Interventional Radiology & MRI. Location: Henry Ford Hospital – Buerki Auditorium, Detroit, Michigan. Sponsor: Henry Ford Hospital, Office of Medical Education. Contact: Shelley L. Helton, Office of Continuing Medical Education, 2799 West Grand Boulevard, Detroit, MI 48202-2689. (313) 876-3073. Approved for: 14 hours Category I Credit.

24-25, Urology Update: 1990 Location: Novi Hilton, Novi, Michigan. Sponsor: William Beaumont Hospital, Department of Urology. Contact: Department of Urology, William Beaumont Hospital, 3601 W. 13 Mile Road, Royal Oak, MI 48073. Approved for: 16 hours Category I Credit.

26, HIV Blood Test Counseling for the Primary Care Physician. Location: Sheraton Oaks, Novi. Sponsor: AMA in cooperation with MSMS. Contact: Eltha Thomas, 535 N. Dearborn St., Chicago, IL 60610. 1-800-621-8335. Approved for: 6 hours Category I Credit.

October

1-2, Update on Pulmonary and Critical Care Medicine. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine. Contact: Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. Approved for: 14 hours Category I Credit.

3, HFH Diabetes Symposium: Primary Care & Subspecialty Management of Diabetes Mellitus. Location: Fairlane Manor, Dearborn, Michigan. Sponsor: Henry Ford Hospital, Office of Medical Education. Contact: Shelley L. Helton, Office of Continuing Medical Education, 2799 West Grand Boulevard, Detroit, MI 48202-2689. (313) 876-3073. Approved for: 6.5 hours Category I Credit.

10-12, A Symposium in Diabetes Care. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School. Contact: Julie Jacobs, Registrar, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University Of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 936-9800. Approved for: 20 hours Category I Credit.

18-20, 13th Annual Seminar in Diagnostic Ultrasound. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Radiology. Contact: The Registrar, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. Approved for: 14 hours Category I Credit.

28-29, The Difficult Airway. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Anesthesiology. Contact: Julie Jacobs, Registrar, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 936-9800. Approved for: 13 hours Category I Credit.

November

8-9, Congenital Anomalies. Location: Towsley Center, Ann Arbor, Michigan. Sponsor: University of Michigan Medical School, Department of Pediatrics and Communicable Diseases. Contact: Julie Jacobs, Registrar, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. Approved for: 15 hours Category I Credit.

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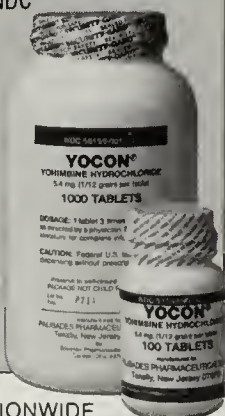
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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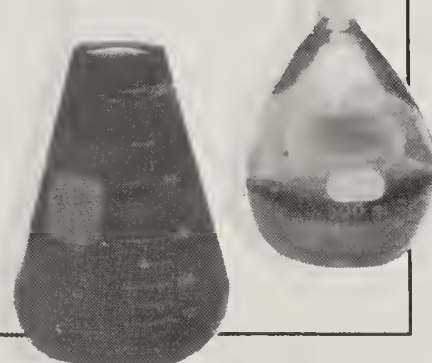
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CRT Management	67	Physician Service Group	1
Eli Lilly	24	PICOM	37
G.D. Searle	49-52	Profee	56
IC System	5	Security Pacific	67
KAB Gloves	75	Stratton-Cheeseman	66
Kidder Peabody	80	Stratton-Cheeseman Risk Management	17,19
Knoll Pharm	11,12	Troy Software	73
Lab of Clinical Medicine	4	US Air Force	25
M-Labs	29	US Army	65

PRESIDENT'S PAGE

Mini-residency program needed

By Susan H. Adelman, MD



What we need is a mini-residency. By this I mean a training program shorter than a residency and longer than a typical CME course or a course in a special procedure. It can be designed for a physician who wishes to perform a new technique, or as a refresher course that a physician might wish to take before a career change. The same format could be used for remedial medical education which a peer review entity might prescribe for an outdated physician. The idea is to allow the physician to gain sufficient proficiency in the subject material to go right out and do it, just as a graduating resident goes out and practices a specialty right after completing a residency.

While Report C of the Council of Medical Education at the I-89 AMA meeting alludes to this idea, so far most states have responded to an AMA questionnaire about it by "indicating that there is a definite need for a focused CME program, but that planning is in its early stages." Only five states have such a plan in operation.

The mini-residency would complete the program of enhanced medical licensure and discipline that Rep. Gubow's committee proposes for Michigan. This plan suggests separating licensure from discipline, and it emphasizes the importance of identifying health care professionals who are functioning at a suboptimum level, then

concentrating on reeducating them before applying sanctions.

The legislation which established the new national Physician Data Bank requires all peer review organizations and all entities which provide health care to report serious sanctions against physicians and other health care workers. It also requires all professional liability insurers to report all cases in which they paid out money on behalf of a physician.

Case identification will be facilitated further when insurers, hospitals, Medicaid, and Medicare develop the ability to collect data, compare the performance of individual professionals with peers, and perform meaningful quality and outcome assessments. The BCBSM Physician Retrospective Profiling Project is an early example of such a system, though it cannot identify subspecialists year, a capacity which it needs to be really useful. So far, few hospitals in Michigan have sophisticated MIS systems, as do few managed care systems.

When these institutions and systems can capture accurate, meaningful statistics which permit true peer group comparisons of utilization, quality and outcomes, then they too will be able to identify physicians who might benefit from referral to a mini-residency.

State licensing boards should be able to mandate referrals to what the AMA calls focused educational experiences, and MPRO or any other peer review entity should be able to suggest them. Once so referred, the physician needs to be able to find a suitable program.

Major teaching institutions which now offer regular residencies are the logical ones to develop the mini-residencies. They will have to be at least one to three months long to be worthwhile, and ideally it should be possible to customize them to suit the needs of an individual physician. If a surgeon needs to learn a new operation or new concepts in perioperative care for a certain condition, it may take several weeks or months to acquire enough expe-

rience in a mini-residency to feel confident enough to use these new skills.

It may be impossible for a physician to take this much time out from a solo practice without concomitant coverage by a locum tenens. In order to make a mini-residency program work, a flexible locum tenens program also will have to be developed, and so will the necessary understandings with the physicians's hospitals and other contractual agreements.

If the physician has electively entered the mini-residency in order to learn a new skill or to regain confidence in old unused skills, it may not be as necessary to conclude the program with testing or certification. If the physician has been enrolled at the request of a licensing board or the suggestion of a peer review agency, it might be prudent for the program to offer appropriate testing or a certificate of training which the physician could present to the board prior to resuming practice. This option too would have to be developed.

First we must ask our hospitals and medical schools to look into the best possible way to set up such a program. Issues of tuition, integration with regular residency programs, accreditation standards, and legal responsibility for the physician's patient care activities all will need to be worked out.

Think of the service that such a program could perform, though! Think how much more self-confidence some of us might have! Think how much more confidence the public would have in our profession! Think of how much harder it would be for lawyers to claim that they need to sue doctors to be sure the medical profession will maintain high standards. One wonders whether it would even lower our professional liability rates, just as it would lower our risk. It certainly would not hurt to ask.

Doctor Adelman is MSMS president.

MICHIGAN MEDICINE

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*"Spectrum of Medicine
in the '90s"*

*1990 MSMS Annual Scientific
Meeting Preview*

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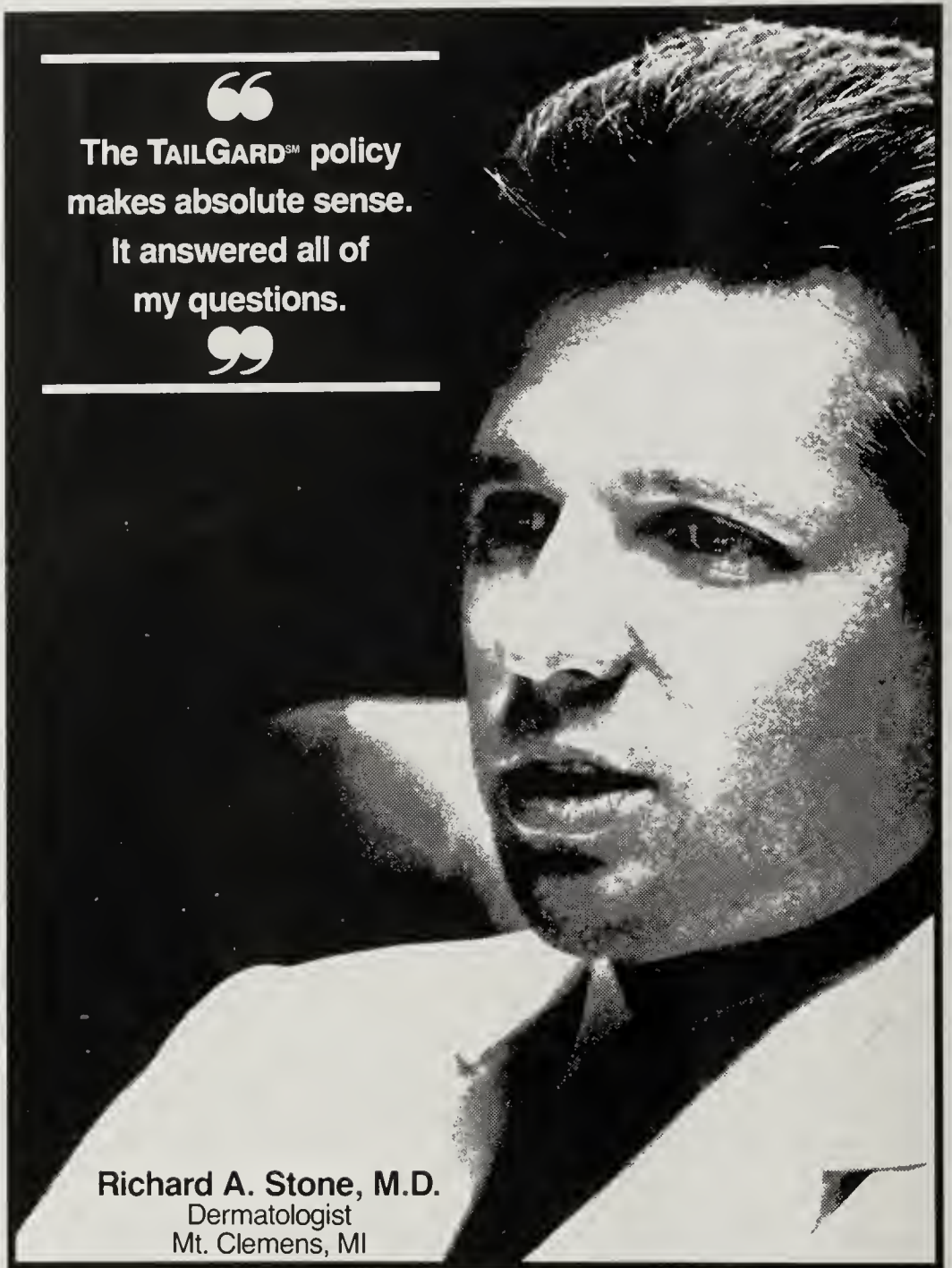
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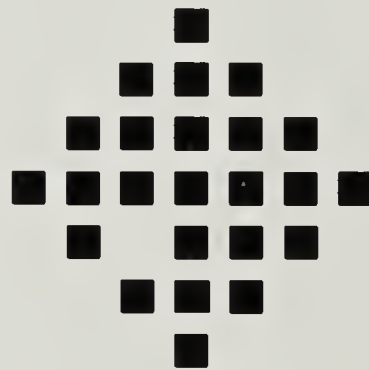
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14 COVER STORY

"Spectrum of Medicine in the '90s" is the theme of this year's Annual Scientific Meeting, scheduled for November 6-8 at the Hyatt Regency Hotel in Dearborn. The spectrum is the key to the 1990 ASM as it symbolizes today's wide-ranging challenges to the Michigan physician, and hence the broad scope of topics covered. MSMS members can learn more about this important event in this month's cover story.

F E A T U R E S

23 POLICYHOLDER SEEKS FAIR PAYMENT FROM THE BLUES

An account of a woman who is fighting the Blues for adequate reimbursement for knee surgery and is winning.

BY CLAUDIA SKUTAR

26 PHYSICIAN OFFICE REIMBURSEMENT PROBLEMS

There are a variety of sources available to physicians from MSMS and BCBSM regarding reimbursement.

BY ROSE B. HEALD

29 PHYSICIANS AND HIV-POSITIVE PATIENTS

Michigan physicians will face a growing number of HIV-positive patients in the next decade.

BY CLAUDIA SKUTAR

35 BUILDING A HEALTHIER MEDICAID SYSTEM

This feature profiles Kevin Seitz, director of Medical Services Administration for the State of Michigan, who is dedicated to improving the Medicaid system.

BY PATRICK WOLSKI

37 MSMS MEDICAID LIAISON COMMITTEE

A profile of this MSMS committee and its role as an independent voice for physicians.

BY PATRICK WOLSKI

39 MICHIGAN ORTHOPEDIC SOCIETY

This third in a series of articles on specialty societies in Michigan shows that for orthopedic surgeons, delivery of care has become a serious issue.

BY RALPH WARD

41 VIEWPOINT

Support legal effort to invalidate workers' compensation fee schedule.

BY TOM GEORGE, MD

45 BOARD OF MEDICINE ACTIONS

D E P A R T M E N T S

7 Letters

9 Newsfronts

10 Physicians in the News

47 New Members

51 Deaths

52 Category I Courses

53 Meetings

54 Classifieds

56 Advertising Index

58 President's Page

"When it comes to health insurance, MSMS members have many lessons to learn"

BY SUSAN H. ADELMAN, MD



Page 14



Page 29



Page 35

In next month's issue of *Michigan Medicine*:
Elections and Ballots.

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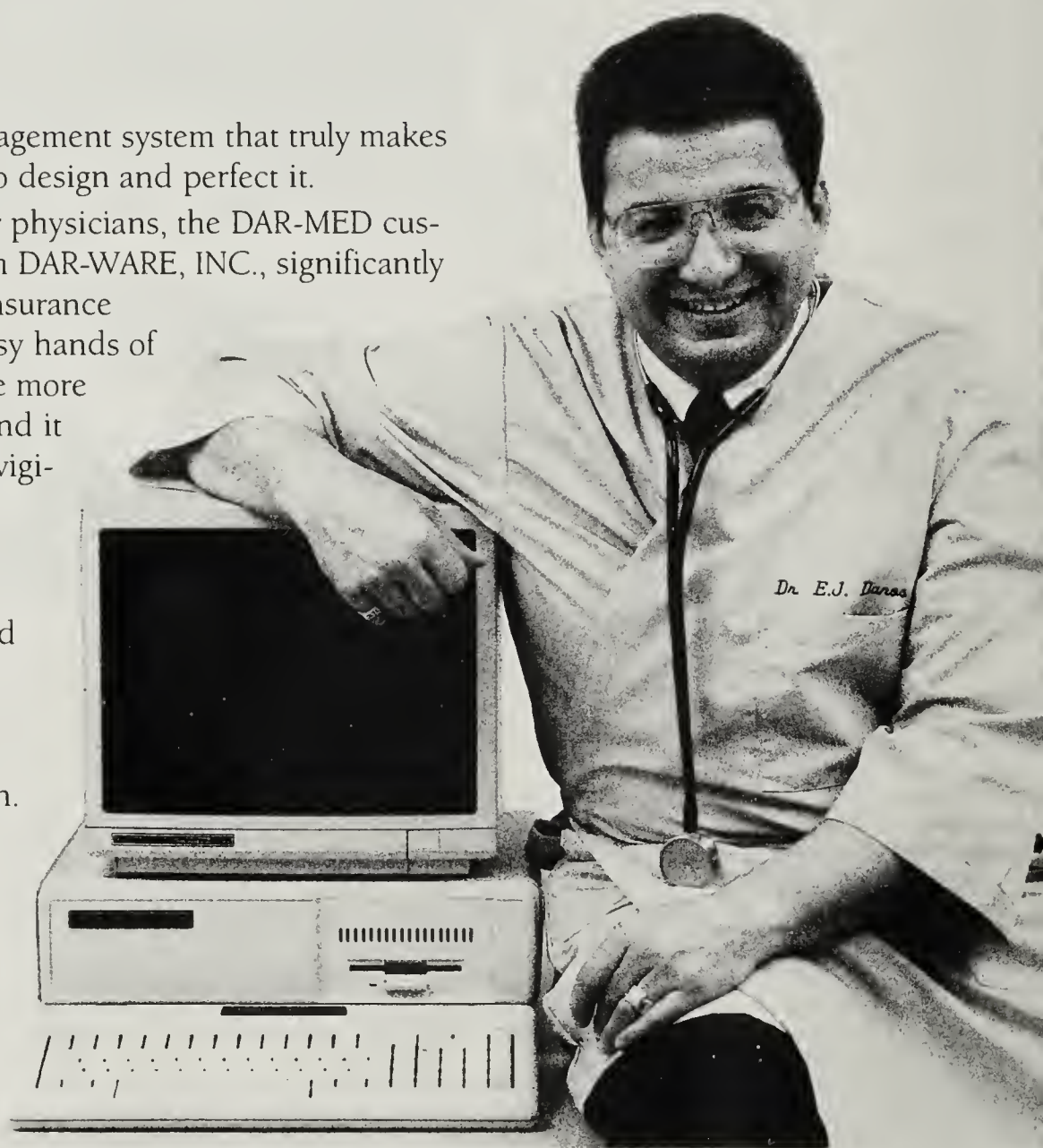
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Letters from Our Readers

Government must address increase in Repetitive Motion Injuries

Handicapped workers in Michigan have more protection now that Governor Blanchard has signed a handicappers' civil rights bill. This is good news for some of the handicappers, but the fastest growing segment of the disabled population seems to have been excluded from coverage under the law. Thousands of employees are developing Repetitive Motion Injuries every year, yet they are not protected under this legislation.

According to an article reprinted from the *News Michigan Service*, this law "requires employers to accommodate the needs of handicapped employees if the handicap is not related to the required task." Since most RMI's are directly related to the "required task," those employ-

ees are not protected under the law.

In Michigan today there are an estimated 1.5 million disabled citizens, and that number is increasing rapidly. The Michigan Occupational Safety and Health Administration statistics show that in 1987 there were 8,696 case "disorders due to repeated trauma." Just one year later that figure doubled to 17,141 cases. Michigan's economy cannot afford to lose that many employees every year without suffering dire consequences.

Nationally, Carpal Tunnel Syndrome and Repetitive Motion Injuries account for 48 percent of all reported job-related disorders. Employees afflicted by these insidious diseases are impaired and often become crippled, depending on the extent and severity of the nerve damage. The government must come to grips with the problem. Funds must be allocated for

study and research on these disabling diseases. For more information, interested persons may write to ACTSA, P.O.Box 6730, Saginaw, MI 48608.

*Timothy W. Ader
Executive Director
American Carpal Tunnel
Syndrome Association*

Physicians should utilize computers to their advantage; join co-op

I am in the process of forming a physicians computer co-op which is intended to further the use of computers in patient care. The co-op would involve physicians only, and involve itself with no financial or billing programs and concentrate mostly upon the use of computers in handling patient records, gathering patient data for practice management or research purposes and improving patient documentation.

In my opinion, and those of other physicians scattered around the state, we need to encourage our fellow MSMS members to utilize computers to their advantage. Recently one of the malpractice carriers expressed interest in a five percent malpractice premium discount to physicians who utilize computer documentation in their office practices.

I would like to invite all physician members of the MSMS to contact me for information on starting a statewide co-op. The co-op would involve educational materials, possibly a newsletter and sharing of software programs. We also might band together to benefit from group purchases of equipment, etc.

Anyone interested should get in contact with me.

*Ed Messina, MD
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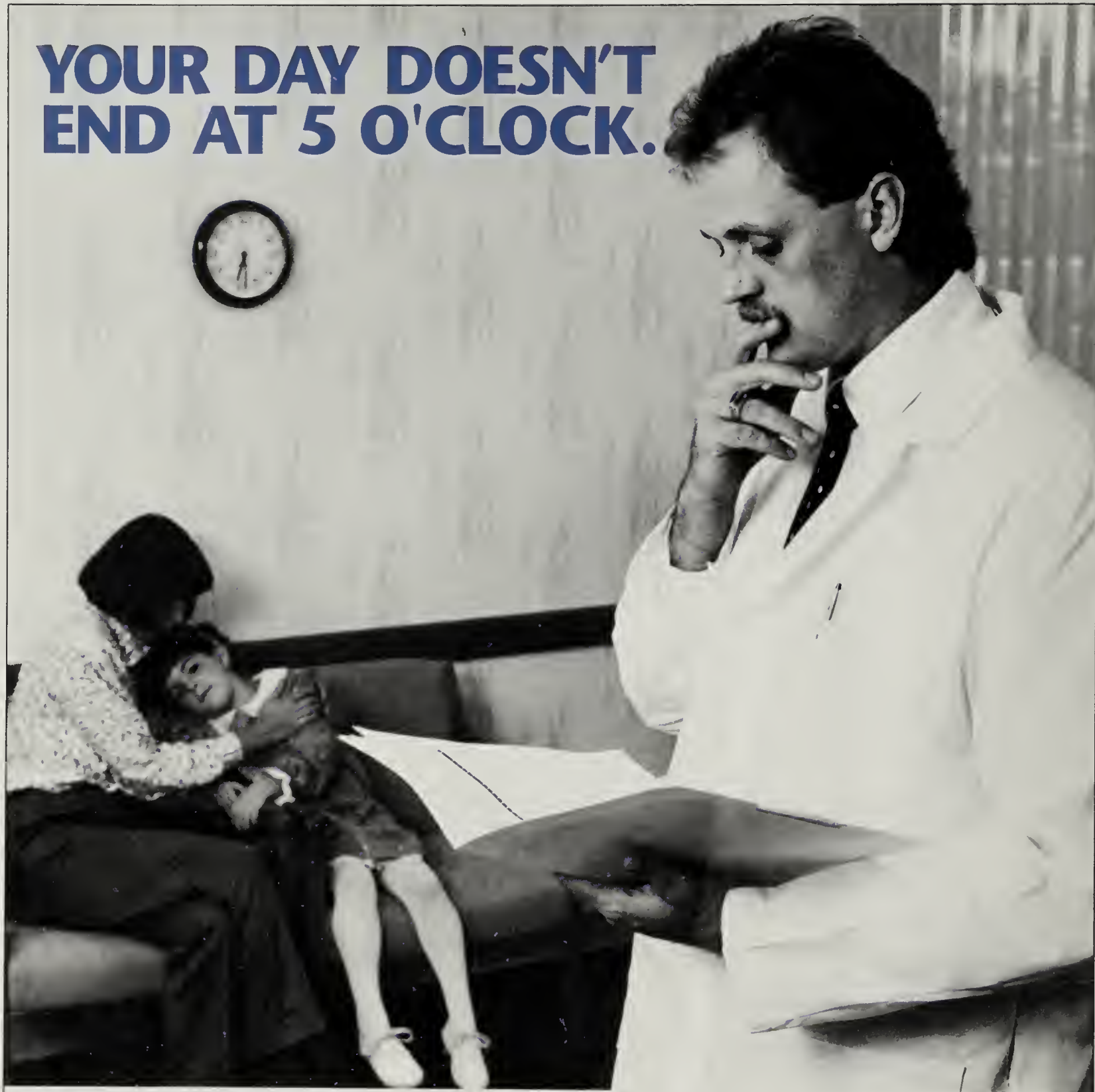
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MEDICAL NEWSFRONTS

INDEX

Patients on life support systems may feel pain, U-M researcher reports	9	US, European docs unprepared to provide genetic counseling for intermarried couples, U-M says	10
Samaritan receives grant to help pregnant substance abusers	9	MSU center to focus on mind's healing power	10
WSU residents tops in nation	9	Oakland University receives grant for older adult project	11

Patients on life support systems may feel pain, U-M researcher reports

A researcher at the University of Michigan has powerful new evidence that some people in persistent vegetative states may still be able to feel pain.

The finding could have an important impact on both the medical care of brain damaged patients maintained on life-support systems and on legal cases contesting the right of such patients to die.

"I believe that people who have sustained very severe damage to the cerebral cortex, but whose subcortical structures have been spared, should be assumed to have the ability to feel pain," says Kenneth L. Casey, MD, professor of neurology and physiology, and chief of the neurological service at Ann Arbor Veterans Administration Medical Center. "They may not be able to do anything else, but they can probably feel pain."

The Michigan researcher studied 18 patients with cortical damage, comparing them with 17 patients who had sustained damage below the cortex and 26 "controls" whose brains were normal.

Doctor Casey's findings stem from his theory —

developed with Ronald Melzack, MD, of McGill University in Montreal — that pain, as experienced by humans and other primates, has two distinct components.

He describes these components as "sensory/discriminative" quality which informs us where, when, and how strongly a painful stimulus occurs on our bodies; and a "hedonic" quality, which allows us to perceive that a stimulus is, in fact, hurtful and unpleasurable.

In normal people, Doctor Casey believes, these two aspects of pain perception appear to function as one; but with a stroke or other neurological damage, they frequently disengage and can be observed as distinct functions.

The classic illustration of such separation is the stroke patient who winces when his Achilles tendon is squeezed, but can't say what hurts (loss of sensory/discriminative perception); or the prefrontal lobotomy patients who can identify a painful region on his body but is no longer troubled by the pain (loss of hedonic perception).

In his brain-imaging studies of the sensory function of human stroke patients, Doctor Casey was able to establish that normal sensory-discriminative perception of pain requires an intact, functioning cerebral

cortex. Conversely, hedonic perception in patients with severe cortical lesions requires only that subcortical structures including the thalamus, be spared. Doctor Casey describes the thalamus as "a major relay communication center for the cerebral cortex."

The 18 patients Doctor Casey studied have suffered severe cortical damage on one side of the brain and retained only a crude ability to locate stimuli — some could only say on which side of the body sensation was occurring — but they all reported feeling pain at normal or near normal threshold levels. Based on this finding, Doctor Casey concludes that people with damage to *both* sides of the cortex — a condition that could produce a vegetative state — could also feel pain.

The most immediate implication of his findings, Doctor Casey says, is that care providers must take all necessary precautions to prevent pain in patients with intact subcortical pain pathways.

Samaritan receives grant to help pregnant substance abusers

Samaritan Health Center, a 375-bed Mercy hospital in Detroit, has received a \$226,000 grant from the Michigan Department of Public Health to establish a program of care for chemically-dependent pregnant women.

According to Suzanne Sattler, IHM project director, the grant will be used to identify pregnant women in their first trimester who are in need of substance abuse treatment and coordinate the services they receive.

Case managers for the project will target women on the east side of Detroit

through contacts with schools, community organizations and other service providers, according to Sattler.

The program, which began serving clients Sept. 1, is offered by Samaritan, in cooperation with Henry Ford Hospital, the Detroit Health Department and several other participating organizations. An advisory committee comprised of community representatives and service providers will oversee the project.

WSU residents tops in nation

The Wayne State University School of Medicine has reported a 90 percent pass rate by 47 of its internal medicine residents on the American Board of Internal Medicine Certifying Exam taken last fall. This rate places WSU among the top five percent for all large internal medicine training programs in the United States.

Ernest Yoder, MD, director of the residency training program, related that two residents placed within the top 99 percent in the country. The certifying exam covers general internal medicine as well as its specialized areas.

US, European docs unprepared to provide genetic counseling for intermarried couples, U-M says

Western physicians may be headed for a crisis in genetic counseling in the next 20 years because of the dearth of research on consanguineous marriages — those between close relatives.

According to population researcher Alan Bittles at the University of Michigan, currently at least 10 percent of

Continued on page 10

Continued from previous page

the world's population, more than 500 million people, are married to close relatives, mainly reflecting socioreligious preferences, as in the case of Muslims and some Hindu and Buddhist populations.

As communities of migrants from developing countries continue to grow in the United States and Europe, so does the likelihood that a physician will be required to counsel a consanguineous couple or to treat their children.

Bittles, a geneticist at Kings College, University of London, and a Fulbright Fellow in the U-M Population Studies Center, defines consanguineous unions as any marriage between second cousins or closer relatives. His research in South India and Pakistan during the last 10 years has focused mainly on first-cousin and uncle-niece marriages and their impact on birth rates and infant mortality.

Although he believes that the deleterious effects of inbreeding have been greatly exaggerated, due at least in part to Western cultural bias, Bittles argues that the medical community is grossly unprepared to meet the challenge of providing appropriate genetic counseling for consanguineous couples because so little is known about the patterns of inheritance and the frequency of multigene disorders in such marriages.

A typical situation is a family in which a spouse or child has a cleft lip or palate, a common hereditary birth defect. "With couples who are not related, we can predict almost exactly the chance that the defect will recur," Bittles says.

"But with an inbred family, effectively we have no statistical basis on which to make a prediction. With so little prior experience, our ability to give genetic counseling is drastically reduced."

While birth rates continue to decline in Western nations, where marriages between

close relatives are statistically rare, Bittles notes that birth rates in the majority of highly inbred nations continue to rise rapidly. For example, in Pakistan, where consanguineous marriages account for up to 50 percent of the total, the United Nations predicts an increase in the population from 115 million to 268 million over the next 35 years.

Bittles cites studies indicating that throughout North and West Africa and West and South Asia, marriages between close relatives are contracted by or on behalf of 20 percent to 50 percent of couples. By comparison, rates of consanguineous marriage in Central and South American countries average three percent to five percent and 0.1 percent to 0.3 percent in the United States.

Bittles is conducting an ongoing study of birth patterns among 112,000 couples in southern India, who include Hindus, Muslims and Christians.

Women in close-relative marriages have their first child an average of nine to 10 months earlier than their non-related counterparts. In fact, the closer the family relation between the partners, Bittles found, the younger the mother's age at first birth.

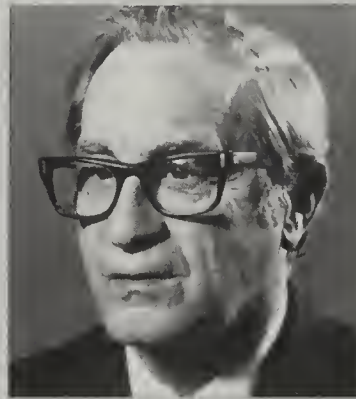
While studies have shown that children of intermarried couples have a slightly higher rate of infant mortality and morbidity due to genetic disorders, Bittles believes that this mortality is offset by the fact that since women in close-relative marriages tend to marry younger and have their first child earlier, they have more children overall.

MSU center to focus on mind's healing power

A center designed to research what role the mind plays in the body's healing

Continued on page 11

Physicians in the News



Clarence S. Livingood, MD, chairman emeritus of Henry Ford Hospital's Department of Dermatology, has received the 1990 American Medical Association (AMA) Distinguished Service Award for meritorious service in the science and art of medicine. He is the only dermatologist to receive the award. A respected clinician, investigator, and teacher, Doctor Livingood is best known for his efforts throughout his career to improve the stature of dermatology and to enhance its growth by his participation in national educational and interspecialty policy-making organizations. As part of this effort, he has served as a dermatology representative on many national medical boards and committees, including the AMA. Doctor Livingood is the first physician at Henry Ford, in Michigan, and in dermatology to be recognized with such an honor.

Jose Evangelista, MD, and **Stella Evangelista, MD**, Bloomfield Hills, have been entered into the International Institute of Metropolitan Detroit's Hall of Fame. The Evangelistas are the first couple ever accorded the honor and are the first Filipino recipients. Doctor Jose Evangelista is a past president of the Association of Philippine Physicians in

America, the Philippine Medical Association of Michigan and Circulo Pampangueno of America. Doctor Stella Evangelista has served as an officer in both the national and state Philippine medical associations. She became the first Asian appointed to the Michigan State Board of Medicine four years ago. Governor James Blanchard recently appointed her to another four-year post.

Ahmad Aburashed, MD, chief, Section of Gastroenterology, Mount Carmel Mercy Hospital, Detroit, is recipient of the "Golden Stethoscope Award." The award is given to a private practice physician with the ability to teach in the education and training field for young interns that are doing their residency at Mt. Carmel. This distinguished award is given in the light of being a "role model" above and beyond the call of duty. Residents that have completed their three years at Mt. Carmel unanimously voted Doctor Aburashed physician of the year.

Larry R. Lloyd, MD, Saint John Hospital, Detroit, and **Donald W. Weaver, MD**, Wayne State University Department of Surgery, have been named "Young Surgeons" by the Michigan Chapter of the American College of Surgeons. This selection honors young surgeons who show qualities of outstanding leadership and integrity. Doctors Lloyd and Weaver will attend the Young Surgeons Seminar at the American College of Surgeons in Chicago in the Spring of 1991.

Continued from page 10

process is being established at Michigan State University.

MSU has accepted a grant of \$285,000 from the John E. Fetzer Institute for the establishment of the Center for Meaning and Health. The grant will support the center's first year of activity, with the potential of providing up to \$1 million over a five-year period.

The center will promote and coordinate a broad range of research and educational efforts that tie a person's health or illness to how he or she thinks about health and illness-related issues.

"We see this joint effort with MSU," said Robert Lehman, Fetzer Institute president, "as our flagship program in bringing to medical research and education the important new science of how the mind and body work together in human health."

"Our major goals are to improve physician training and promote greater involvement of the individuals in the doctor/patient relationship," said Howard Brody, MD, one of the center's co-directors and director of MSU's Center for Ethics and Humanities in the Life Sciences.

Doctor Brody points out that the center's research and teaching will be interdisciplinary, taking advantage of the various human health programs and broad range of behavioral and social sciences available at MSU.

With an emphasis on education, the center will schedule faculty development programs, sponsor seminars featuring guest lecturers, coordinate pilot studies and establish a computer-based mechanism for identifying relevant material in a wide variety of disciplines. Courses in the mind-body link also will be offered to MSU students enrolled in health-related curriculums.

The center's agenda will include several research projects. For example, psychosocial and patient-interviewing skills will

be taught intensively to one group of doctors in training, with the future effectiveness of this training being rigorously evaluated. Another project will investigate the effects of stress and relaxation on cellular immunity.

Oakland University receives grant for older adult project

The Oakland University Continuum Center has begun a community-based health education project for professional staff development in senior centers and adult day-care centers.

The three-year project is funded by a \$432,778 grant from the W K Kellogg Foundation of Battle Creek.

The training is designed both to improve the quality of service older adults will receive, and to lessen the possibility of institutionalization of the elderly.

Specifically, the project includes developing, piloting, evaluating and refining a competency-based program in three Michigan communities. Producing and disseminating relevant materials for replication purposes is also a primary focus of the project.

The Continuum Center, a community service arm of Oakland University, is a multifaceted university training resource. Since its founding in 1965 as a women's center, supported by the Kellogg Foundation, the center has evolved to meet the diverse training needs of business, the professions and private individuals in many communities. Foremost among its accomplishments is more than 20 years of educational services to older adults.

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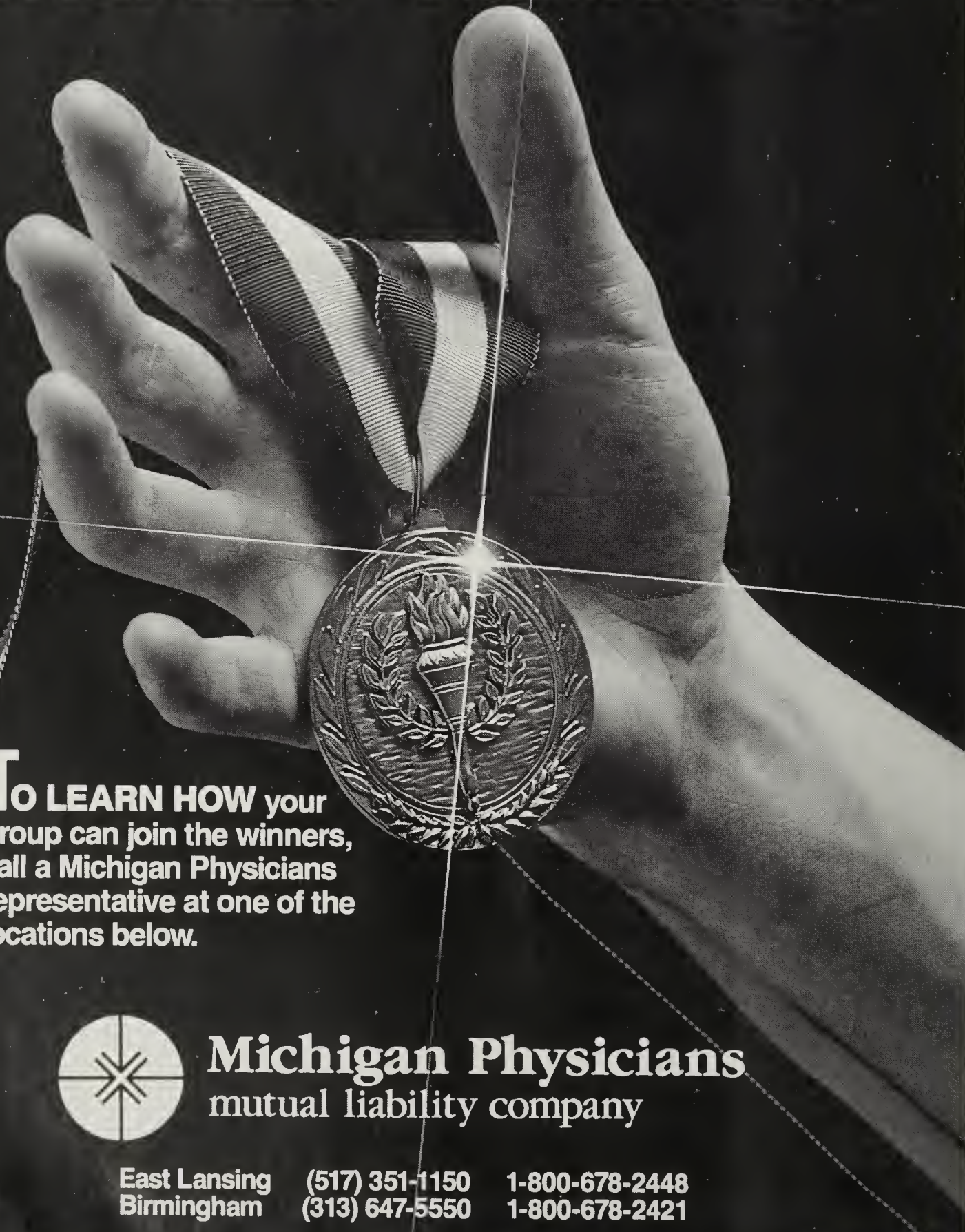
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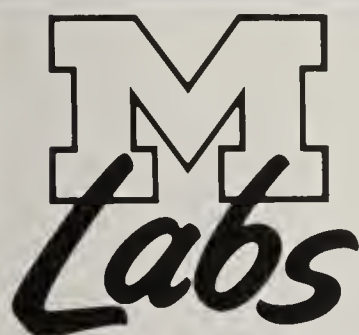
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Spectrum of Medicine in the 90's

The Michigan State Medical Society offers a program which takes you through a spectrum of selected diseases which pose a threat to the health of our nation.

At the **Annual Scientific Meeting**, Michigan physicians may accumulate a total of 20 Category I Credit hours. Don't miss this CME opportunity.

**1990 MSMS
Annual Scientific Meeting**
November 6, 7, 8
Hyatt Regency, Dearborn





Doctor Nagle

MSMS Annual Scientific Meeting Highlights Spectrum of Medical Issues

Each year more than 1,000 Michigan physicians gather for the **MSMS Annual Scientific Meeting** to learn the latest information and to exchange ideas about a variety of medical topics. This year physicians will meet at the Hyatt Regency Dearborn on November 6-8 to tackle a spectrum of medical issues ranging from cardiovascular disease to AIDS.

As chairman of this year's meeting, I'm pleased to say that the Planning Committee has worked hard to develop 50 up-to-date courses on a cross-section of these issues which cuts across all specialties and affects all patients.

We've selected diseases and conditions which not only threaten the health of our nation's citizens, but which also challenge physicians to play a larger societal role in maintaining good health for everyone.

In addition to the regular half-day medical courses, we're offering a Wednesday session on health care rationing, conducted by John O'Brien-Bell, MD, past president of The Canadian Medical Association. We're also presenting a special, half-day plenary session on Thursday which will discuss important environmental issues. Preliminary topics will cover the role of physicians in their communities, toxics in the home and workplace, medical waste, and the status of Michigan's environment.

Attendance at the **Annual Scientific Meeting** can provide physicians with up to 20 Category 1 credit hours, which is four-fifths of the 25 credits required annually.

To encourage physicians who have never attended the meeting to participate this year, the Planning Committee has developed a new "Adopt a Doctor" program. This program offers physicians who have attended previous Annual Scientific Meetings one-third off their registration fee to bring a physician who has never attended. New attendees also will receive one-third off their registration fee this year, with or without a sponsor.

In the following pages you'll find a capsule schedule of events, a schedule of special events, a list of exhibitors and a registration form to help you in planning your attendance at this very informative meeting.

The **Annual Scientific Meeting** provides a focal point for Michigan physicians on the spectrum of medical issues and challenges facing them. I look forward to seeing you all there. Introduce yourselves, and let me know what *you* want for future meetings.

--Conrad E. Nagle, MD, Chairman



Capsule Schedule of Annual Scientific Meeting

Tuesday, November 6

7:30 AM

Great Lakes Exhibit Center Open
Registration

8:30 AM

Concurrent Scientific Courses (*run until Noon*)

- Basic Cardiac Life Support
- Cardiovascular Disease & Elderly
- Rheumatology
- Immunology/Lupus
- Ovarian Cancer
- Managing Diabetes
- Pediatric Gastrointestinal Disease
- Rehabilitation/Stroke Patient

Clinical Poster Display (*all day*)

12 Noon

Luncheon for All Registrants

1:30 PM

Concurrent Scientific Courses (*run until 5:00 p.m.*)

- Arrhythmias Workshop
- Chronic Fatigue
- Lung Cancer
- Medical/Legal/Competency
- Preconception Care
- Radiology
- Substance Abuse/Children
- Suicidal Patients
- Transfusion Medicine

6:00 PM

Reception
MSMS ASM Planning Committee

Wednesday, November 8

7:00 AM

"Early Bird" Plenary Session on Rationing Health Care
Hubbard Ballroom (*Coffee & Rolls included*)

7:30 AM

Great Lakes Exhibit Center Open
Registration

8:30 AM

Clinical Poster Display (*all day*)

Concurrent Scientific Courses (*run until Noon*)

- Basic Cardiac Life Support
- Surgical Problems/Infants & Children
- Thyroid Disorders
- Occupational Medicine
- Emergency Mgt./Substance Abuse
- Head & Face Pain
- Interpretation of ABG's
- Skin/Psyche/Soma
- Sports Medicine

9:00 AM

Board Meeting
Michigan Allergy Society

12 Noon

Lunch for All Registrants

Luncheon

MSMS Committee on Concerns of
Women Physicians

Luncheon

MSMS Specialty Society Presidents

Luncheon/Executive Board Meeting

Michigan Occupational Medical Association

1:30 PM

Concurrent Scientific Courses (*run until 5:00 p.m.*)

- Allergy
- Breast Exam/Abnormalities
- Critical Care Medicine
- Concerns in Ethics
- Cutaneous Signs/Infectious Disease
- Environmental/Occupational
- New Applications/Narcotics
- Colon & Rectal Surgery
- Pediatric Emergencies
- Urology

3:00 PM

Board Meeting/Reception/Dinner/Program
Michigan Orthopaedic Society

6:00 PM

Reception
Michigan State University College of
Human Medicine Alumni Association
Reception
Wayne State University Medical
Alumni Association
Reception/Dinner
Michigan Occupational Medical Association

6:30 PM

Reception/Dinner
Physician Service Group, Inc.



Thursday, November 8

7:00 AM

"Early Bird" Plenary Session on Caring for the Environment
Hubbard Ballroom (*Coffee & Rolls included*)

7:30 AM

Great Lakes Exhibit Center Open
Registration

8:30 AM

Concurrent Scientific Courses (*run until Noon*)

- Caring for the Environment
- Basic Cardiac Life Support
- Atherosclerosis
- Neurology Update
- Plastic Surgery
- Performing Arts Injuries

12 Noon

Luncheon for All Registrants

1:30 PM

Concurrent Scientific Courses (*run until 5:00 p.m.*)

- Plastic Surgery
- Spinal Injuries
- Pulmonary Medicine
- HIV and AIDS/Primer
- Ocular Manifestations/Diabetes
- Psychopharmacology
- Women and Heart Disease
- Dizzy Patient
- Viral Hepatitis

6:00 PM

Reception/Dinner

Michigan Academy of Plastic Surgeons

Reception/Dinner/Meeting

Michigan College of Nuclear Medicine Physicians

Schedule of Special Events

Clinical Poster Displays

Tuesday and Wednesday, November 6-7 (all day)

"Early Bird" Plenary Sessions I and II

Hubbard Ballroom

(Coffee and Rolls included)

Wednesday, November 7 at 7:00 a.m.

Thursday, November 8 at 7:00 a.m.

MSMS ASM Planning Committee Reception

Tuesday, November 6 at 6:00 p.m.

MSMS Committee on Concerns of Women Physicians

Luncheon

Wednesday, November 7 at 12:00 noon

MSMS Committee of Specialty Society Presidents

Luncheon

Wednesday, November 7 at 12:00 noon

Michigan Academy of Plastic Surgeons

Reception/Dinner

Thursday, November 8 at 6:00 p.m.

Michigan Allergy Society

Board Meeting

Wednesday, November 7 at 9:00 a.m.

Michigan College of Nuclear Medicine Physicians

Reception/Dinner/Meeting

Thursday, November 8 at 6:00 p.m.

Michigan Occupational Medical Association

Executive Board Meeting/Lunch at 12:00 noon

Reception/Dinner at 6:00 p.m.

Wednesday, November 7

Michigan Orthopaedic Society

Board Meeting/Reception/Dinner/Program

Wednesday, November 7 at 3:00 p.m.

Michigan State University College of Human Medicine Alumni Association

Reception

Wednesday, November 7 at 6:00 p.m.

MSMS Physician Service Group, Inc.

Reception/Dinner

Wednesday, November 7 at 6:30 p.m.

Wayne State University Medical Alumni Association

Reception

Wednesday, November 7 at 6:00 p.m.



Over 20 New Reasons to Visit the Exhibits

Now, more than ever, MSMS members will want to visit the exhibit hall during the **MSMS Annual Scientific Meeting**, November 6, 7, & 8, at the Hyatt Regency Dearborn. Room has been made for over twenty new exhibit spaces for firms representing both your personal and professional needs.

The trained representatives of over 90 firms will now be there to discuss the details of their products and services in a relaxed atmosphere:

- * with no patients waiting in your outer office
- * with no emergencies to call you away

The exhibit hall is an important part of the **Annual Scientific Meeting** and is the site of registration for all courses and special events.

Some of the firms you'll see represented are listed below by category. Further information is available from Lori Randall at MSMS headquarters.

Pharmaceuticals

Allen & Hanburys (Division of Glaxo, Inc.)
Boehringer Ingelheim Pharmaceuticals, Inc.
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Janssen Pharmaceutica
Key Pharmaceuticals
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Merck Sharp & Dohme
Parke-Davis
The Upjohn Company
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Clinical Laboratories

Advance Medical/Metpath
Continental Bio-Clinical Laboratory Service, Inc.
Damon Clinical Laboratories
Metric Medical Labs
National Health Laboratories, Inc.
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Preferred Laboratories
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Accent Leasing, Inc.
American Medical Systems, Inc.
Bell Atlantic Tricon Leasing
Davis Smith Medical Dental Employment Service Inc.
Diversified Medical Sales, Inc.
Firestone X-Ray Corporation
I.C. System, Inc.
Michigan Bell
Randolph Medical Inc.
Target Equipment Leasing, Inc.

Patient Home Care

Metro Rehabilitation Services, Inc.
Perry ComfortCare

Computers/Computer Services

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Colonial Valley Software, Incorporated
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Management Systems Engineering
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Educational Resources

Encyclopedia Britannica, USA

Protection

Blue Cross & Blue Shield of Michigan -
Automated Input Concepts
Blue Cross & Blue Shield of Michigan - Field Services
Comerica Bank
Disability Determination Service
The Equitable - Association Members Retirement Program
Michigan Physicians Mutual Liability Company
Physicians Insurance Company of Michigan
Physicians Service Group, Inc.
Professional Asset Management
Prudential-Bache Securities
Retirement Plan Consulting Group
Stratton Cheeseman & Associates

Other Exhibitors

Henry Ford Health System
Michigan Headpain and Neurological Institute
University of Michigan Medical Center
U.S. Army Medical Department
Wyandotte Hospital & Medical Center



Registration Form 1990 MSMS Annual Scientific Meeting November 6, 7, 8 Hyatt Regency Dearborn

Physicians must make their own hotel reservations prior to 10/5/90 directly with the Hyatt Regency Dearborn at 313/593-1234.

Name _____
(Please print) (first) (initial) (last)
Street _____
City _____ State _____ Zip _____
County _____ Phone () _____ Previous attendee? Yes ☒ No ☐
MSMS Member: Yes ☐ No ☐ Resident ☐ Specialty _____ Other _____

Adopt-a-Doctor Discount*

Take one-third off your registration fee if you bring a physician who has never attended an MSMS Annual Scientific Meeting.
Your "adopted doctor" is _____

Choosing your courses

Please check the courses you wish to attend. For each, please indicate a second choice in case the first is already filled.
Maximum attendance figures have been set for each course, depending on room size.

Tuesday Morning, November 6

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ Basic Cardiac Life Support
- ☐ Cardiovascular Disease and the Elderly
- ☐ Current Practice in Rheumatology
- ☐ Immunology and Disease:
- ☐ Lupus, The Master Mimic
- ☐ Management of Ovarian Cancer
- ☐ Managing Diabetes
- ☐ Pediatric Gastrointestinal Disease
- ☐ Rehabilitation of the Stroke Patient

Lunch

A deli sandwich will be provided at no extra charge for paid registrants. Advance notice is requested so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

Tuesday lunch ☐

Wednesday morning, November 7

(7:15 - 8:15 am, No Fee)

- ☐ "Early Bird" Plenary Session on Rationing Health Care
- (continental breakfast included)

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ Basic Cardiac Life Support
- ☐ Common Surgical Problems
- ☐ In Infants and Children
- ☐ Common Thyroid Disorders
- ☐ Doctor, Is My Work Making Me Sick?
- ☐ Emergency Management of Substance Abuse Patients
- ☐ Head and Face Pain
- ☐ Interpretation of Arterial Blood Gases
- ☐ Skin/Psyche/Soma - The Golden Years
- ☐ Sports Medicine for Primary Care Physicians

Wednesday lunch ☐

Thursday Morning, November 8

(7:15 - 8:15 am, No Fee)

- ☐ "Early Bird" Plenary Session on Environmental Issues
- (continental breakfast included)

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ Caring for the Environment
- (continued from morning plenary session)
- ☐ Basic Cardiac Life Support
- ☐ Controversies in Atherosclerosis
- ☐ Neurology Update: Parkinson Disease, Headaches, Dementia and Neuropathy
- ☐ Performing Arts Injuries
- ☐ Priorities In Repair and Reconstruction of the Extremities

Thursday lunch ☐

Tuesday Afternoon, November 6

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ Arrhythmias Workshop
- ☐ Chronic Fatigue: Multidisciplinary Workshop
- ☐ Lung Cancer
- ☐ Medical and Legal Questions of Competency
- ☐ Preconception Care: Concepts and Issues
- ☐ Radiology for Clinicians
- ☐ Substance Abuse in Children
- ☐ Suicidal Patients in General Medical Practice
- ☐ Transfusion Medicine

Wednesday Afternoon, November 7

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ Allergy 1990
- ☐ Breast Examination and Abnormalities
- ☐ Critical Care Medicine
- ☐ Current Concerns in Ethics
- ☐ Cutaneous Signs of Infectious Disease
- ☐ Environmental and Occupational Exposures
- ☐ New Applications for Narcotics
- ☐ Office Practice of Colon and Rectal Surgery
- ☐ Pediatric Emergencies
- ☐ What's New in Urology

Thursday Afternoon, November 8

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

- ☐ A New Look at Clinical Problems in Plastic Surgery
- ☐ Acute Spinal Injuries
- ☐ Clinical Pulmonary Medicine
- ☐ HIV and AIDS: An Outpatient Primer
- ☐ Ocular Manifestations of Diabetes
- ☐ Potpourri of Pulmonary Problems
- ☐ Psychopharmacology for the Non-Psychiatrist
- ☐ Silent Epidemic: Women and Heart Disease
- ☐ The ABC (DE)'s of Viral Hepatitis
- ☐ The Dizzy Patient: Evaluation and Treatment

Your payment

MSMS Members:

\$45 for each half-daycourse

MSMS Members with "retired status":

\$25 each half day

Non-Members: \$75 for each half-day course

Residents: \$20 for each half-day course

Students: NO CHARGE - Limited Enrollment
(lunch tickets may be purchased)

Multiply total number of half-day courses by appropriate fee:

_____ x \$45 (members) = \$ _____

_____ x \$25 (retired) = \$ _____

_____ x \$75 (non-members) = \$ _____

_____ x \$20 (residents) = \$ _____

_____ x \$10 (student lunch) = \$ _____

Adopt-a-Doctor Discount* = \$ _____

TOTAL = \$ _____

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, designates this activity meets the criteria for a maximum of 20 credit hours in Category I toward the requirements for Michigan relicensure and of the Physicians Recognition Award of the AMA, provided it is completed as designed.

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50.1-100	14.4¢/min.	12.2¢/min.	11.5¢/min.
100.1+	13.6¢/min.	11.6¢/min.	10.9¢/min.

POLICYHOLDER

seeks fair payment from the Blues

By Claudia Skutar

Margaret Van Camp thought the most difficult part of her knee surgery would be spending time on crutches, but she found out that her biggest battle would be to get Blue Cross Blue Shield of Michigan (BCBSM) to pay for the care.

It's not often that an individual consumer chooses to go head-to-head with a large corporation in resolving a problem, but that's what she decided to do when she received what she felt was unsatisfactory reimbursement for a medical claim from BCBSM.

Van Camp, a Birmingham resident, was having knee trouble in 1989 when she consulted her physician, MSMS member Jerry H. Rosenberg, MD, a Southfield orthopedic surgeon. He recommended arthroscopy to determine what was wrong with her knee. Because Doctor Rosenberg is a nonparticipating BCBSM provider, Van Camp knew that she would be responsible for a portion of the surgery's cost. She telephoned BCBSM to determine how much of the surgery they would cover to get an idea of what she could expect to pay.

Following standard procedure, BCBSM told Van Camp that it could not provide that information until a bill for surgery had been submitted.

"I decided to go ahead with the surgery...because I knew I'd be on crutches for what I thought was a few days," Van Camp explained. "I had the surgery, found out that instead of taking a short time, it took almost three hours, and I was on crutches for almost six weeks."

Doctor Rosenberg performed the arthroscopy on Van Camp in June 1989. He charged \$1,500 for the service, which he described as an average fee.

When Van Camp received a \$710 reimbursement from BCBSM, she was surprised at what she felt was a low amount for the work that had been performed, and decided to pursue the issue. To determine if Doctor Rosenberg's fees were in line with what other physicians charge for the same service, Van Camp called other specialists to inquire about their fees for arthroscopy.

"They all charged around \$1,200-\$1,500, depending on the circumstances," Van Camp said.

"Reimbursement by BCBSM has always been lower than other companies," Doctor Rosenberg said. "They're the biggest and they pay the least. They can do that because they're so big."

Doctor Rosenberg provided Van Camp with information on other insurance companies which reimburse the full amount for the surgery for comparison with BCBSM reimbursement, according to Van Camp.

Reimbursement a common problem

"Many of my patients have had reimbursement problems with BCBSM, not just Margaret Van Camp," Doctor Rosenberg said.

Van Camp asked Doctor Rosenberg to send another report to BCBSM, thinking that upon a second review the company might change its reimbursement on the claim. Instead, the claim for further reimbursement was denied.

Not wanting to let the matter drop, Van Camp contacted BCBSM directly in September 1989, requesting a complete copy of her file and the rejection of her claim review. According to Van Camp, BCBSM did not respond to her request. This was the first of several requests Van Camp made to BCBSM by phone and letter for information but which yielded no answers other than BCBSM had paid its customary fee for the service, said Van Camp.

Frustrated with the company, Van Camp sent a letter to Attorney General Frank Kelley in October 1989, with a carbon copy sent to the Michigan Insurance Bureau. Although Kelley did not respond with a letter to BCBSM until April 1990, the Michigan Insurance Bureau did contact Van Camp in November 1989 to inform her of what to do next.

The Michigan Insurance Bureau, under authority of P.A. 350 regulating BCBSM, oversees a hearing process for subscribers like Van Camp with complaints against insurance companies. John McClintic, an Insurance Bureau regulation specialist, informed Van Camp that her first step under law was to file a complaint in writing with BCBSM. By law, BCBSM must respond to such a complaint within 30 days. McClintic forwarded Van Camp's corre-

spondence to BCBSM with a request that it be treated as a formal complaint.

"In an average year our department receives about 1,000 complaints against BCBSM," McClintic said. "These are mainly payment and rate complaints."

Once the Insurance Bureau receives them, they are forwarded to BCBSM for resolution, McClintic said. Those that aren't resolved end up back at the Insurance Bureau for a review and determination. In 1989, McClintic conducted about 90 review and determinations on subscriber complaints levied against BCBSM.

BCBSM responds

Rudolph Difazio, director of Media Relations for BCBSM, did not dispute the number of complaints the Insurance Bureau receives on his company but did say that they need to be viewed in perspective.

"We have 4.3 million members, which is 45 percent of the population in Michigan," he noted. "BCBSM pays 80 million claims per year and that number is growing. One thousand complaints out of that is, I think, a relatively small number."

When BCBSM responded to her complaint with a letter explaining its reasonable charge reimbursement policy, Van Camp requested a conference with BCBSM.

This time BCBSM responded, according to Van Camp, with a letter refusing a conference, stating that under P.A. 350 only people whose coverage is underwritten by BCBSM can make such an appeal. Van Camp is insured under her husband's health care plan through his employer, Ford Motor Company. According to BCBSM, this plan is administered, but not underwritten, by BCBSM.

Because BCBSM was unwilling to respond to Van Camp's written complaint for a conference, Van Camp once again appealed to the Insurance Bureau. She requested a review and determination of her case, which McClintic set up on February 27, 1990. BCBSM representatives and Van Camp attended.

In a position paper handed to McClintic at the session, BCBSM maintained, as it

Continued on next page

had previously in denying Van Camp's reimbursement claims, that it's maximum screen for the arthroscopy is \$710, the maximum amount payable under her contract.

Additionally, BCBSM stated in the paper that the Insurance Bureau is without authority to review Van Camp's case under P.A. 350 because BCBSM administers her husband's insurance plan and does not underwrite it. BCBSM contended that Ford's plan is self-funded and therefore not subject to state laws intended to regulate insurance.

"On March 12, 1990, I got a review and determination from the Insurance Bureau in my favor. It said that they (BCBSM) should pay the additional \$790 plus interest," said Van Camp.

"You can't call the decision at the informal hearing a finding in the sense that we as layman know it because it doesn't have the same weight as law," said Difazio.

BCBSM had 60 days after the review and determination to set step two of the Insurance Bureau's complaint resolution process into motion, which it did. According to McClintic, when either party is dis-

satisfied with an Insurance Bureau review and determination, it has the option of a second hearing before an administrative law judge. That judge makes a proposal to the Insurance Commissioner, who rules on the case. A second hearing currently has been set for Nov. 26.

Difazio said that the issue of reimbursement is not a new one, and has been around since BCBSM began reimbursement on the basis of costs.

"In general, this case reflects the tension that exists in the health care environment in Michigan and across the country," Difazio said. "Our reimbursement is the result of pressures on us to contain costs."

Van Camp said that she chose Doctor Rosenberg to perform her surgery, even though he was a nonparticipating provider, because he had treated her children previously and she trusted him.

"If I didn't want to pick my physician, I could pick an HMO and never have to pay another penny, but I'm not willing to do that," said Van Camp. She explained that she chose BCBSM as an insurance plan because it was the only plan offered by her husband's employer which allowed her to choose her own physician.

"I am willing to pay part, but when (reimbursement) is less than 50 percent, there's something wrong," she said. ■

Claudia Skutar is communications specialist for MSMS.

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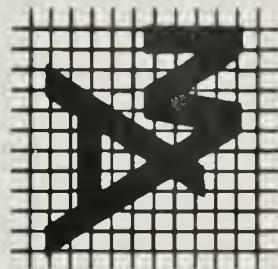
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Physician office reimbursement problems

HELP IS AT HAND

By Rose B. Heald

"I'm a new doctor starting practice in Michigan. How can I get a Blue Cross/Blue Shield of Michigan (BCBSM) provider number?"

"BCBSM is arbitrarily down-coding claims submitted for intermediate office visits. How can I get appropriate reimbursement for the care provided?"

"BCBSM contacted my office regarding a post-payment audit they will be conducting. Do I have to provide the information they requested?"

Physician offices routinely grapple with these and many other reimbursement problems and often may not be aware of the various resources available to them from MSMS and BCBSM. Summarized below, for easy reference, are services available to physician office staffs from MSMS and BCBSM.

BCBSM Field Representatives

BCBSM has organized four regional offices around the state to assist physicians at the local level with complex reimbursement problems, including serious billing and cash flow problems. BCBSM divided the state into four regions: Southeast Michigan, Lansing area, Grand Rapids area and Northern Michigan. Bellow are the telephone numbers for each of the regional offices.

When contacting the regional office, it is helpful to identify the county in which you are located so the appropriate consultant can be identified.

For additional information about provider consultants in each area, refer to the June 1, 1989, issue of the BCBSM *Record*. In addition, each individual regional office has been profiled in the *Record*: Southeast Michigan, December 15, 1989; Lansing area, May 1, 1990; Grand Rapids area, June 1, 1990; and Northern Michigan, February 1, 1990.

Medicare Professional Relations Representatives

BCBSM is the Michigan Medicare carrier and provides support to the state's physicians on Medicare issues through two professional relations representatives.

They are available to travel throughout the state to meet with physicians and their staff.

The Medicare Professional Relations Representatives may be reached at (313) 225-7378, or write to Medicare Part B, Mail Code 1501, 600 Lafayette East, Detroit 48226-2998. Routine information requests, such as covered benefits, should be directed to Government Provider Inquiry at (800) 482-4760 and (313) 225-8222.

Seminars

Seminars on coding, practice management, reimbursement and Medicare issues are offered throughout the year by MSMS

Region I	Provider Consultants		Kent, Barry Joann Mann (616) 956-5800
(Northern) Oakland Pat Hanserd (313) 486-2373	Genesee, Lapeer, St. Clair Ken Trapp (313) 486-2372	Marylin McGuire (517) 337-5257	Region IV Manistee, Wexford, Crawford, Grand Traverse, Benzie, Leelanau, Antrim, Charlevoix, Cheboygan, Mackinac, Emmet, Chippewa Maureen Dunlavy (616) 947-5740
(Southern) Oakland Irene Sharako (313) 486-2373	Hart Co-ordinator John McComas (313) 486-2378	Saginaw, Shiawassee, Huron, Tuscola Mike Myrand (517) 337-5259	
Wayne Norb Hnatuk (313) 486-2384	Trust Program Cathy Maxwell (313) 486-2374	MESSA Representative Pat Filker (517) 337-5257	
Wayne Nancy Miller (313) 486-2371	Region II Clare, Gladwin, Arenac, Isabella, Midland, Bay, Gratiot, Clinton, Eaton Joe Ditzhazy (517) 337-5259	Region III Mason, Lake, Osceola, Oceana, Newaygo, Mecosta, Muskegon, Montcalm, Ottawa, Ionia, Allegan John Beadling (616) 956-5800	
Wayne Pat Halso (313) 486-2371	Ingham, Livingston Bonnie Fisk (517) 337-5259	Van Buren, Kalamazoo, Calhoun, Berrien, Cass, St. Joseph, Branch Frank Smith (616) 956-5800	Missaukee, Roscommon, Ogemaw, Iosco, Alcona, Oscoda, Kalkaska, Grand Traverse, Otsego, Montmorency, Alpena, Presque Isle Jack Ahart (616) 947-5740
Monroe, Washtenaw Priscilla McGuire (313) 486-2374	Jackson, Ingham (MSU) Hillsdale, Lenawee		Keweenaw, Houghton, Ontonagon, Gogebic, Iron, Baraga, Marquette, Monominee, Alger, Delta, Schoolcraft, Luce, Dickinson Dick Maher (906) 228-9118
Sanilac, Macomb Betty Busby (313) 486-2372			

and its subsidiary, Physician Service Group, Inc. The seminars, which are offered in locations around the state, are taught by professionals with many years of experience in the field. For a schedule of upcoming seminars, contact Physician Service Group, Inc. at (517) 336-7570.

BCBSM also offers billing seminars for physician office staff that are scheduled throughout the year. Schedules and registration forms for these seminars are published in the BCBSM *Record*. There is no charge for par physicians, but attendees must register in advance.

MSMS will be offering a fall series of seminars for physicians and their key office staff that will cover billing issues, Provider Inquiry, the new BCBSM fee schedule and the physician participation agreement. Implementation of contract provisions will be discussed, as well as the new fee schedule and using and accessing BCBSM.

Four half-day seminars will be offered around the state. Further details will be published in *Medigram*.

BCBSM Provider Inquiry

The Provider Inquiry Department responds to both written and telephone inquiries from physicians, as well as other providers, including hospitals, facilities, dentists and vision care providers. According to BCBSM, 73 staff members are dedicated to telephone servicing, with an additional 25 dedicated to written inquiries. Telephone inquiry handles an average of 90,000 calls per month.

BCBSM acknowledges that the phone blockage rate is 35-40 percent, but this is a marked improvement over the past year when the blockage rate was 90 percent.

Over 40 percent of calls are to obtain benefit information and another 20 percent to determine eligibility of a patient. A very

small percentage of calls are to question the status of checks or payment amounts or to obtain claim filing information. The balance of calls are to determine a claim's status or to question rejected claims.

Provider Inquiry should be the initial step in answering routine reimbursement questions. As noted above, BCBSM field representatives should be consulted on more complex issues. However, if these avenues, for whatever reason, do not produce useful results, physicians also may contact MSMS staff in the Medical Economics Department.

BCBSM Customer Inquiry

BCBSM subscribers may readily determine benefit coverage by contacting one of the regional BCBSM customer inquiry departments that are located around the state. Listed below are telephone numbers and walk-in offices to which physicians may refer their patients.

MSMS/BCBSM Liaison Committee

The Liaison Committee is composed of MSMS physicians and includes physician representatives from BCBSM. The committee meets quarterly to discuss board policy issues affecting the physician community and also pursues individual physician complaints that may affect a general category of physician reimbursement. The committee concentrates on longstanding policy problems that cannot be resolved through usual channels. Inquiries regarding the committee should be directed to the MSMS Medical Economics and Health Care Delivery Department.

Rose Heald is chief of health care programs for MSMS.

REGIONAL CUSTOMER SERVICE CENTERS

Location (Address for Written Inquiries)	Telephone Numbers	Inquiry Services Provided	Regular Business Customer telephone calls are routed to the Grand Rapids Center from these areas:
Southeastern Michigan Customer Service Center	Regular Business Customer telephone calls are routed to the Southeastern Michigan Center from these areas: Flint 313-733-3080 Ann Arbor 313-996-0766 Port Huron 313-985-8126 Utica 313-254-9100 Pontiac 313-335-3140 Mt. Clemens 313-469-2170 Western Wayne County 313-961-6128	Telephone	Grand Rapids Area 800-972-9797
Lansing Customer Service Center 1500 Abbott Rd. East Lansing, MI 48823	Medicare/Complementary Lansing Area 800-322-0607 Regular Business Lansing Area 517-699-3200 Remainder of Area Code 517 800-258-8000	Walk-in Telephone Written	Medicare Program Marquette Area 800-562-7802 Regular Business Marquette Area 906-228-9112 Remainder of Area Code 906 800-562-7884
Western Michigan Customer Service Center 611 Cascade W. Parkway, SE Grand Rapids, MI 49506	Medicare/Complementary Grand Rapids Area 800-442-8020	Walk-in Telephone Written	Marquette Customer Service Center 230 W. Washington Marquette, MI 49855

CUSTOMER OFFICES: WALK-IN SERVICE ONLY

These offices cannot respond to written or telephone inquiries. They provide walk-in service only.

Port Huron 415 Andrew-Murphy Port Huron, MI 48060	Alpena 135 W. Chisholm Street Alpena, MI 49707
Muskegon 3375 Merriam Road Muskegon Heights, MI 49444	Flint G-3267 Beecher Road Flint, MI 48504
Saginaw 3150 Enterprise Drive Saginaw, MI 48603	Traverse City 1305 East 8th. Street Traverse City, MI 49684
Oakland/Macomb 6100 Auburn Road Utica, MI 48087	Kalamazoo 3624 S. Westnedge Kalamazoo, MI 49008

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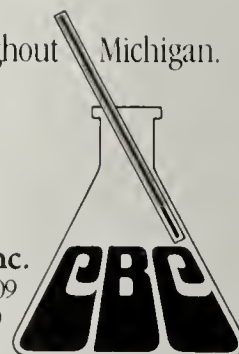
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Michigan physicians will face a growing number of HIV-positive patients in the next decade, according to MSMS member Lawrence R. Crane, MD, associate professor of medicine, Division of Infectious Diseases, Wayne State University School of Medicine.

"Within 10 years there will not be a primary care physician in Detroit or in southeastern Michigan that doesn't have patients with this, and we really need to look toward improving physician education," said Doctor Crane, who attended the Sixth International Conference on AIDS held recently in San Francisco.

"I think that Michigan physicians are poorly educated on the disease," he said. "This is going to have to change when you realize that probably almost one percent of the adults in Detroit are infected with the virus at this time."

Doctor Crane joined other Michigan health professionals in attending this year's conference, "AIDS in the Nineties: Science to Policy," which drew more than 10,000 researchers, clinicians, activists, policy makers, interested individuals and journalists to share information and debate issues on AIDS.

"This is the biggest conference of its kind regarding AIDS," Doctor Crane said of the June conference. "This one is really... multidisciplinary in scope because it includes people from clinical sciences as well as social sciences."

More education necessary

Improving physician education on acquired immune deficiency syndrome is necessary to guarantee that every doctor is prepared to handle his or her patients, Doctor Crane noted.

A current study, recently reported in the *New England Journal of Medicine*, documents spread of the AIDS virus further into the heterosexual community.

The study, titled "Sentinel Hospital Surveillance System for HIV Infection," was conducted by the Centers for Disease Control (CDC) at 26 hospitals around the country. It involved HIV testing of discarded blood specimens after all routine testing had been completed by each hospital. Specimens were excluded from the study if patients had been treated for AIDS, HIV infection, or if they were at special risk for HIV infection (because of drug use, gunshot wounds, etc.). At The Detroit Medical Center, 8,000 anonymous blood specimens were sampled for HIV infection as part of this study.

"These are patients admitted to the medical center that you would not suspect



MICHIGAN *physicians to face growing numbers of HIV-positive patients*

By Claudia Skutar

of being infected with HIV," Doctor Crane explained, "and the rate of men (infected with the virus) between the ages of 25-45 is about two percent. The rate in women is about one percent of the same age bracket. The rate in children is .5 percent."

Doctor Crane compared the data uncovered in this study on HIV infection rates for The Detroit Medical Center with data from a more suburban-rural hospital in southeastern Michigan that also participated in the study.

"Their rates (of infection) are extraordinarily lower," he pointed out. "Overall, .77 percent of people admitted to this medical center are positive. In that rural, suburban medical center the rate is .13 percent."

Infected females increasing

The data from the study also indicates a dramatic increase in the ratio of infected females to males, suggesting signs of greater spread of the virus among heterosexuals, according to Doctor Crane.

He noted that the curve of total numbers of AIDS cases reported in this country started to flatten about 1987 and has reached a plateau.

"The thing that is really striking is that all of this plateau is suburban white male," Doctor Crane said. "The curve is still going upward and onward in black and Hispanic people, among drug users and heterosexual women."

The importance of AZT, which he believes contributed to the decline in the number of cases reported, was highlighted at the San Francisco conference.

"It's pretty much accepted that the plateau is because of AZT...and that's about the time that AZT became widely available," he said.

Part of the reason the plateau in reported cases has occurred within the white male population, Doctor Crane said, is because those individuals can afford the drug.

He added that by "beginning AZT early when a person's immune system is relatively intact...you can reduce the risk in the short term of developing AIDS by at least half."

According to Doctor Crane, however, studies have shown that AZT may have a limited impact on some AIDS patients.

"When you treat a person with AIDS with AZT...the drug seems to be effective for a year or two and then the drug will begin to lose its punch," he said. "The patients will develop new infections, start losing weight again, and then die."

"In those patients, it's quite clear now that the virus which is resistant to AZT occurs. This may be an important limiting factor in AZT treatment for AIDS."

Doctor Crane said investigators have found that those cases occur most often when AZT is used with people where the disease has progressed further, adding that in the earlier stages of HIV infection the drug is more effective.

Vaccine on the horizon

Doctor Crane said he left the conference feeling confident that there will a vaccine developed in the future to prevent transmission.

"There may actually be vaccines we will be able to use in therapy as well, but it's going to be...several years before we know which vaccine is going to be best and how effective it is going to be," he said.

Randall Pope, chief, Special Office on AIDS Prevention, Michigan Department of Public Health, noted that there are a variety of vaccines currently being tested, with several promising tracks.

"The fact that a vaccine can be developed is now established," said Pope.

Statewide statistics

As of July 1, 1990, there were 1,729 reported cases of full-blown AIDS in Michigan since the epidemic began in 1981. Of that number, 1,022 cases have resulted in death. Pope also said there have been 1,520 cases of HIV infection reported in Michigan since April 1, 1989 when a law requiring this reporting took effect.

Changing pattern of transmission

Studies being done in Detroit on HIV

Continued on next page

infection indicate the pattern of virus transmission is changing there from transmission through gay males and drug abusers to heterosexual transmission, according to Doctor Crane.

"Our ratio of men to women is two to one, which is extraordinary. About half of one percent of our newborns have antibodies and we're seeing HIV in adolescents," Doctor Crane explained. "This suggests that the pattern of transmission in Detroit is changing to that of what you would see in Africa, a lot of heterosexual spread."

Most of the AIDS cases from heterosexual transmission which Doctor Crane has observed occurred in women whose male sexual partner was involved in drugs. If they become pregnant, they stand a 30 percent chance nationally of passing the HIV virus to their infants. In Detroit that percentage is higher, about 40 to 50 percent, Doctor Crane noted.

"I think it's 40 to 50 percent because we have a lot of undernourished fetuses, and fetuses are exposed to drugs and other factors," said Doctor Crane.

Other urban areas such as New York and Chicago are showing similar rises in

heterosexual transmission, according to Doctor Crane. However, the pattern of transmission for rural southeastern Michigan is just the opposite of that in urban Detroit, with the virus showing up predominantly in men and very little in women and children. This fact underscores the evidence on changing transmission trends in urban areas.

Doctor Crane believes that certain factors are responsible for the changing epidemiology of AIDS in urban areas compared to other parts of the country. These factors, he said, include the drug epidemic, poverty, poor education and the lack of health resources.

Doctor Crane said he was pleased to learn at the conference that about 25 percent of the people infected even after 11 or 12 years are still well. He noted that investigators are only now beginning to understand why some people remain well while carrying the virus. Scientists and physicians attribute their survival to:

— Long-term survivors have very high counts of suppressor cells or T8 cells which now seem to be important in preventing the virus from growing or passing from cell to cell.

— Individuals lack certain antibodies which actually promote the infection.

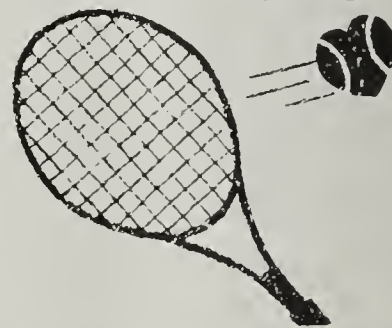
— They tend to be infected with strains of the virus that may not be as virile.

"You can estimate that for every case of AIDS there may be 100 people infected that haven't yet progressed to AIDS," Doctor Crane said. "There is not going to be one clinician by the year 2000 in southeastern Michigan that doesn't have contact with HIV patients. We need to go much further than what we are doing." ■

Claudia Skutar is communications specialist for MSMS.

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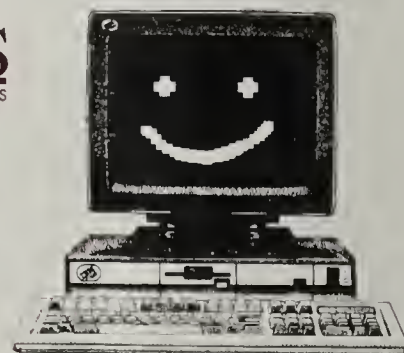
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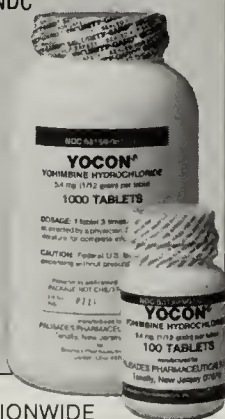
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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References

1. *USP DI Update*, September/October 1988, p 120.
2. *Br J Clin Pharmacol* 1985;20:710-713.
3. *Data on file*, Lilly Research Laboratories.
4. *Scand J Gastroenterol* 1987;22(suppl 136):61-70.
5. *Am J Gastroenterol* 1989;84:769-774.

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Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given

an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H₂-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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*Kevin Seitz —
Working to build a
healthier Medicaid
system*

By Patrick R. Wolski

Kevin Seitz is someone who, in his own words, "has always been attracted to uphill battles." Five years ago, he got one. In 1985, he accepted the position of director of the Medical Services Administration for the State of Michigan. Since then, Seitz has labored at the head of the Medicaid program, making changes and trying to provide health care for those who would not otherwise receive it.

When Seitz took over Medicaid, he inherited an outdated, unwieldy, troubled agency. The department had been under a staff freeze for several years and, he remembers, "it was really dysfunctional." There were tremendous backlogs of prior authorization claims for durable medical equipment, as well as 400,000 pended claims for Medicaid reimbursement. Additionally, the agency was under investigation for mismanagement. Understaffed and overloaded, the agency was unable to effectively do what was necessary to provide the health care that was needed.

"My first task," he recalls, "was to assess what resources were needed and to get them." Working closely with the Department of Social Services (DSS), he began to revamp the system. Staff was increased from 425 to 520. Backlogs decreased by approximately 50 percent — "about where they should be," he says. Prior authorization claims that once took months are now turning over in two days. Besides changing the Medicaid system itself, he has worked closely with legislators and MSMS to strengthen enforcement of fraudulent abuse statutes regarding state agencies. "We have turned what was at first a very negative experience into a real positive experience," he explains.

The changes which Seitz have made to the Medicaid program have not been just systematic. Seitz has taken the initiative to modernize the technical aspects of the

organization, "bringing Medicaid into the 90's," he says. As one of the first state Medicaid agencies in the nation to computerize, Michigan's also was one of the first to be outdated. Under Seitz, new changes have been enacted to improve office equipment to an acceptable level. New computers have been ordered to bring up-to-date the outdated technology and make the agency more user-friendly to participants. Field representatives have been added to help alleviate physician problems with the Medicaid system, and the number of billing seminars to assist with the cumbersome system for payment have been doubled.

Despite these changes, problems still exist. Chief among them is declining physician participation in the Medicaid program. Medicaid reimbursement rates, bureaucratic red tape and high liability for Medicaid physicians all are factors contributing to declining participation, he says.

As for reimbursement rates, Seitz says the problem is neither caused by nor limited to Medicaid patients. He proposes that if every physician donated ten percent of his or her time to assisting Medicaid recipients, the access problem would not exist. "Solutions to this problem are rooted in what we do for the full Michigan population," he says. "If everyone pitches in, the burden isn't that great on any individual person." In addition, Seitz says there is little that can be done about the rate of reimbursement because the dollars simply are not available to pay doctors their regular rates. There are plans to implement a relative value pay scale, but budget cuts have restricted this program until funds become available.

On the issue of liability, Seitz says he understands physicians' concerns, but he feels the problem is bigger than just potential lawsuits by Medicaid recipients. "I have never seen any statistics to prove that

Medicaid patients sue more than other mainstream patients," he emphasizes. He believes Medicaid patients lack the means to appropriate health maintenance and therefore are a sicker population. As solutions go, he supports anything that would help alleviate the burden on physicians, but only if the solution does not cut into federal matching dollars for the Medicaid budget.

With all the changes which have brought efficiency to Medicaid, Seitz's optimism about the future is sometimes dimmed. "I have always believed that the Medicaid program is very important," he maintains, "but a step along the way to a more comprehensive reform." That comprehensive reform has yet to happen. Medicaid patients themselves have become more complicated as well, now divided into some 28 subgroups of eligible care recipients. With this many participants and not enough means, the distribution of funds and care are getting more difficult to administer with a high degree of accuracy. Health care is growing at a rate higher than general inflation, and this will be reflected more every year in Medicaid's budget and its ability to maintain health care for those who need it.

It is evident to Seitz that state government cannot continue to pay escalating Medicaid costs. As he sees it, there is only one other solution — a federally-funded agency. "I don't know if it will be five, 10 or 15 years, but we are getting to a breaking point in terms of the state's ability to support the program," he predicts. With federal funding, the state could rely on a predictable source of financing, while still maintaining control to tailor each program to its needs.

With all the changes that have occurred since Seitz took over, there are still plans to keep improving the system. Short term goals are often tentative, on a day to day basis, but they always seem to be met. Constant improvements are being enacted in service, accountability, and Medicaid systems. Seitz continues to work with the MSMS Medicaid Liaison Committee to help find the priority needs of physicians and how they can be met. Although many other parts of the system have changed, Seitz's goals have not — "to pay for the most appropriate care at the lowest feasible cost, and to make quality health care more accessible."

Patrick Wolski is an intern for MSMS.

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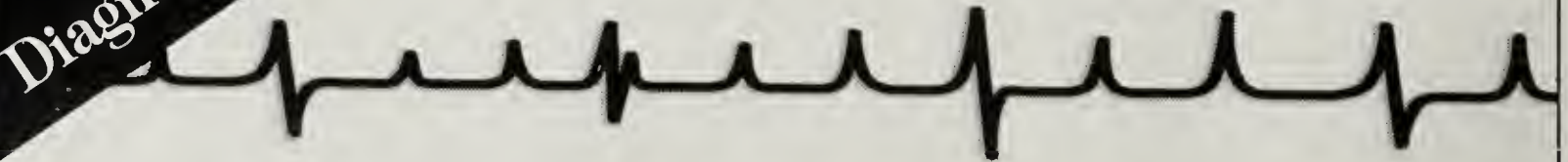
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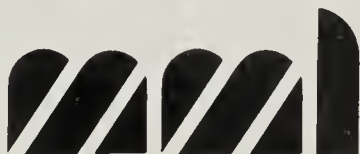
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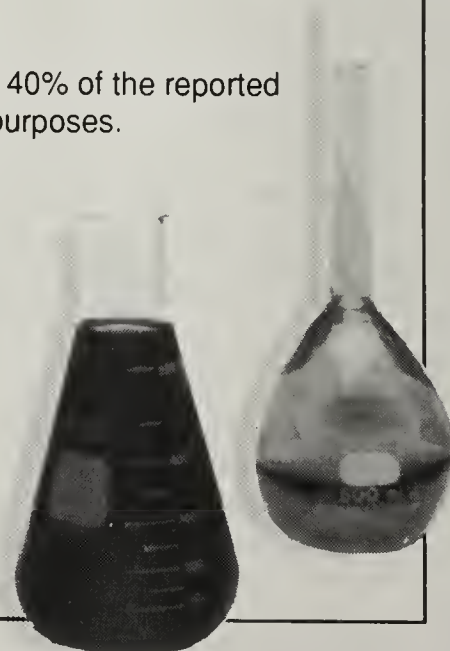
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MSMS

Medicaid Liaison Committee —

An independent voice for physicians

By Patrick R. Wolski

With all the problems surrounding Medicaid, it is difficult to imagine how physicians could have their concerns known without the MSMS Medicaid Liaison Committee. An independent voice for physicians, the MSMS Medicaid Liaison Committee presents the concerns of doctors to top Medicaid officials on a regular basis. By advising Medicaid administrators on the issues, the committee serves as an "open door" to help improve the efficiency of the Medicaid system.

The committee is headed by Cecil Jonas, MD, a Detroit obstetrician who is familiar with Medicaid and the continuing concerns it causes physicians. After several malpractice lawsuits against him in the early 1980's, Doctor Jonas' insurance was cancelled. He had to abandon his 25-30 percent Medicaid practice because he could no longer afford to care for Medicaid recipients. After co-chairing the MSMS Medicaid Liaison Committee for several years, Doctor Jonas eventually took over as chairperson in the mid 1980's. "I thought I could make a difference in the Medicaid system," he says. His role as facilitator between the state agency and physicians allows him to see both sides of the challenging issues that Medicaid presents.

The MSMS Medicaid Liaison Committee meets five to six times per year to discuss the issues and concerns of physicians from around the state. The issues are prioritized, and eventually the selected topics are discussed among members to establish a focused point of view that the committee will endorse. In addition, the committee also establishes what will be the best ways in which to interact with the Department of Social Services (DSS). When the committee has established an accurate representation of the physician viewpoints, head administrators from the DSS meet with the committee to provide insight and to listen to physician concerns. This close relationship between the DSS and the committee is uncommon in other states, according to Doctor Jonas. "The two groups work together to make

sure the system provides the best possible care, with maximum efficiency," he notes.

Aside from keeping Medicaid officials informed on physician concerns, the committee also serves as an informational "watchdog." Its job is to keep MSMS informed of both legislative and bureaucratic decisions that affect Medicaid reimbursement to physicians. The committee is expected to monitor the flow of Title XIX funds, insuring that monies earmarked to provide care and reimbursement to physicians are not bureaucratically misplaced. "It is our job to be sure that Medicaid eligibility does not automatically mean second rate care," Doctor Jonas explains.

In addition to protecting Title XIX funds, the committee is also responsible for protecting the rights of physicians. This protection ends up being in the best interest of both Medicaid administrators as well as health care providers, for it allows physicians to continue rendering care to Medicaid recipients. But even with the protection that the committee gives, physician participation in the Medicaid program has dramatically declined. High insurance premiums, long waiting periods for reimbursement, and extensive red tape, have disillusioned some physicians about contributing their time and skill.

Participation a priority

One priority of the MSMS Medicaid Liaison Committee is to help get physicians back into the program, and help eliminate some of the problems that have caused participation to decline. Liability is "the major concern to physicians right now," says Doctor Jonas, "and there doesn't seem to be a solution to it."

Aside from promoting increased physician participation, the committee has worked on other programs to help increase recipient care. One such endeavor was the Physician Sponsor Plan. This program was highly successful in Michigan, so much so that other states have modeled their own programs after it. It encourages patients to select a doctor that

they will see regularly, instead of going to a different physician every time. In addition, this program has helped obtain greatly needed pre-natal funding — another area of primary concern for Medicaid patients.

Other advancements have been made by the MSMS Medicaid Liaison Committee, working in conjunction with Medicaid staff. Helping to reduce fraud and abuse, higher staffing levels, and exploring alternative reimbursement methods, are just a few of the ways the committee has helped make the system more effective and easier in which to participate.

In addition to changes in the system itself, the committee is supporting the adaptation of an independent pharmacy committee as a cost containment strategy. Pharmaceuticals are a large part of the budget, and the purpose of this committee would be to contain costs in this area by establishing a list of drugs which could be substituted by generics, therefore decreasing expenditures on costly items. With more programs like this, the committee can continue to help ease the financial burden of the DSS.

With the help of the committee, the Medicaid agency is constantly finding ways to trim the budget. But even with the close interaction between the two, the problems facing doctors providing care to Medicaid patients are still a threat. The State of Michigan is losing doctors at an alarming rate, according to Doctor Jonas, who fears this exodus of young physicians will threaten the delivery of care to all Michigan residents, not just Medicaid patients.

"The system is not working," says Doctor Jonas. Until the public recognizes that the physician is as much a victim as are patients, progress will be very slow, he notes. The MSMS Medicaid Liaison Committee wants to raise public awareness about the flaws in the Medicaid system so improvements can be made. It is a continuous uphill struggle to keep providing health care with so many obstacles in the way, Doctor Jonas concluded. ■

Patrick Wolski is an intern for MSMS.

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Michigan Orthopedic Society *Delivery of care has become a serious issue*

By Ralph D. Ward

The following is the third in a series of articles on medical specialty societies in Michigan.

Since the era of Hippocrates, much of the fascination and wonder of medicine has sprung from its attempts to combat the invisible. People have sickened and died from minute, undetectable forms of life, and it has been only within the past century that the physician has been able to identify and combat these invisible microbes with effective medication. Even today, despite our advanced technology, medicine remains very much a matter of faith — faith that unseen microorganisms will be defeated by unseen chemical processes.

But there is a medical specialty that appeals to those with a more fundamental approach to the caring science. These physicians enjoy the challenge of dealing with dramatic, visible conditions — the crippled child, the arthritic joints, the malformed spine, and making a change for the better. This ability to make an immediate, profound improvement in an often crippling condition is what draws physicians to orthopedics.

"I think the rewards of orthopedics are self-reinforcing," says Michigan Orthopedic Society President Lawrence Morawa, MD. "Everything we do can be seen on an X-ray."

The Michigan Orthopedic Society traces its roots back to 1928. Michigan had few trained orthopedic surgeons at the time, yet great demands were made on the talents of these early practitioners. This small, dynamic group combined busy practice at the major Detroit and west Michigan hospitals with teaching programs, such as the orthopedic program at the University of Michigan Medical School.

The spark that actually created the society was formation of the Michigan Crippled Children's Commission in 1927. The commission was called upon to develop standards for the care of indigent children. One aspect was orthopedic care, and orthopedic representatives joined the commission to certify practitioners. The



early specialists certified by the group appreciated the opportunity to discuss cases and socialize, and formed their own association in 1928, the ancestor of today's Michigan Orthopedic Society. The present name was adopted in 1930.

Steady growth

The Society has grown steadily, and today includes more than 300 members, over half of all practicing orthopedic surgeons in the state. A member of the American Academy of Orthopedic Surgery, the group is affiliated with MSMS, and, as Doctor Morawa observes, that "one thing I did as president was to increase the affiliation."

Another recent society priority has been better communication about communicable disease exposure among practitioners. "It's very easy to get cut on a bone," Doctor Morawa notes.

The society's annual meeting each June is a major event, with educational programs and presentation of papers by orthopedic residents. "The society is all about education," says John Colwill, MD, society secretary. "We have to keep up with a rapidly changing field."

Orthopedics is a personally rewarding specialty to its practitioners, through its variety and opportunity to offer dramatic improvements. "This is a very mechanical field," says Doctor Morawa. "There's engineering involved, as in no other medical specialty." The historical involvement of orthopedics with children's conditions

adds to the satisfaction of this surgical field. "One reason I enjoy this work is because these are patients who can do well through treatment." Doctor Colwill agrees. "The emphasis is on function, helping patients do things."

Impressive achievements

The impressive achievements of orthopedics are growing steadily with the development of new technology and new subspecialties. Joint replacement techniques, a recent development in the field, offer dramatic, profound improvement for crippling arthritic conditions. Newer specialties within the orthopedic realm have included hand surgery, and the booming field of sports medicine, although the latter is not yet a recognized specialty. "The vast majority of jobs I do today I didn't even see as a resident," says Doctor Morawa.

Orthopedics faces the same challenges — and sets the same priorities — as do most specialties in Michigan. "Delivery of medical care has become a serious issue," says Doctor Morawa. "Everybody has to receive care." But that mandate has become increasingly difficult for orthopedics, with the state facing an acute physician shortage in the specialty, and the vast majority of orthopedic school graduates leaving the state. A recent study by the American Academy of Orthopedic Surgery found Michigan low among states for orthopedic surgeons. The Michigan Society is helping to fight the problem with resident tracking and recruitment programs.

Liability problems have taken their toll of orthopedic surgeons as well. "The liability crisis does a disservice to patients," according to Doctor Colwill. "Adequate coverage is just not available at a reasonable cost. You're seeing fewer risky procedures, such as spinal procedures or those involving the extremities." Yet despite the challenges, Michigan offers rewards for the surgeon who specializes in orthopedics. "The state has served me very well," says Doctor Morawa. "I wouldn't have my practice anywhere else." ■

Ralph Ward is a Lansing-based freelance writer.

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VIEWPOINT

Support legal effort to invalidate workers' compensation fee schedule

By Tom George, MD



In an effort to enhance Michigan's business climate, the state legislature passed a bill in 1981 calling for the construction of a comprehensive schedule of fees that would be paid to hospitals and doctors who treat injured workers. Under the existing system, health care "providers" were paid their "customary and reasonable" fees by the workers' compensation insurance companies. It was hoped that by setting statewide ceilings for fees, exorbitant charging would be prevented; the insurance companies' payments would decrease, and these savings would be passed on to their customers, business and industry employers.

The intent of this legislation was honorable. However, in the formulation of the fee schedule a series of critical errors was made. The authority to make the fee schedule was set, by law, to expire in 1983 and was given to two state agencies — the Office of Health and Medical Affairs and the Bureau of Workers' Disability. By 1987, these two agencies had not yet been able to make a fee schedule, and for "assistance" they turned to the Economic Alliance, a business and labor association, and allowed it to coordinate the fee schedule's construction. This was the first error. The Economic Alliance convened a series of meetings which were dominated by business and insurance industry representatives. Through these meetings, the Economic Alliance was able to hatch the egg that has become the Workers' Compensation Fee Schedule.

The business representatives pointed out that hospitals and physicians, who care for the poor and uninsured, must

pass some of the cost of this care on to injured workers, and other insured patients. They argued successfully that employers should not have to share the cost of indigent care through workers' compensation payments. Using this reasoning, they based the fee schedule on an outdated Blue Cross Blue Shield model, and rather than cap exorbitant medical cost as intended, used it to slash fees wherever they could. The average physician found his or her "reasonable and customary" fee had thus become "exorbitant and excessive."

The second error was to defer setting of 20 percent of the fees to the insurance carriers themselves, through abuse of the phrase "by report." Traditionally, this designation is used by insurance carriers in lieu of proscribing a fee for a new or unusual medical procedure. But in the Workers' Compensation Fee Schedule, it is widely used throughout, even for some of the most common surgical procedures, such as carpal tunnel surgery. When providing a "by report" service, the physician is required to send in a description of the care to the insurance company, which now has the authority, *given to it by the State*, to decide what the payment will be! Since there are 200 private workers' compensation carriers, and 500 self-insured corporations, it follows there will be a multitude of variable and unpredictable payments for any given "by report" procedure.

In the 1981 law, the legislature also directed the Office of Health and Medical Affairs to establish fair utilization review criteria for workers' compensation medical services. But, in a similar fashion to its handling of the "by report" fees, this power was also abdicated to the insurance carriers. This was the third critical error, for it has allowed the 700 carriers to reject payment for services based on utilization review criteria that they can each arbitrarily set.

Through these manipulations, the fee schedule was designed to reduce medical payments by approximately \$30 million per year. Unfortunately, it contains no provision requiring that the windfall reaped by underpaying physicians and hospitals

be passed on to employers who must purchase workers' compensation insurance. Instead, some of this money will stay within the insurance and utilization review industries.

Now that the State has "solved" its workers' compensation problem, it has set its sights on no-fault auto insurance reform. The carriers are again claiming that the cost of care for the poor is being unfairly shifted through them to the purchasing motorist. Bills recently have been introduced which would trim premiums by making the Workers' Compensation Fee Schedule the mandatory schedule for no-fault auto insurance!

In June 1989, a group of physicians representing several medical specialties brought suit in a Kalamazoo Circuit Court in an attempt to prevent implementation of the Workers' Compensation Fee Schedule. Initially the Court granted a Temporary Restraining Order which delayed activation of the fee schedule. In September 1990, the restraining order was dissolved and the fee schedule allowed to take effect. After motions by the State to dismiss the suit were recently defeated, the trail has been allowed to resume.

Because of the gravity of the problems with the Workers' Compensation Fee Schedule, and because of the proposals to extend its use to other areas, the physician plaintiffs in the legal action feel it is important to continue their challenge. In order to help finance the lawsuit, we have organized The Alliance for Michigan Physicians and Workers' Health Inc. (AMPWH), and are actively recruiting new members. If you care for injured workers, or provide any emergency treatment, then this issue affects you. Please join us in our efforts.

The plaintiffs would like to thank those physicians who have previously made financial contributions directly to us, and ask that donations be made by joining AMPWH. (Box 1605, Kalamazoo, MI 49007). ■

Doctor George is in private practice in Kalamazoo.

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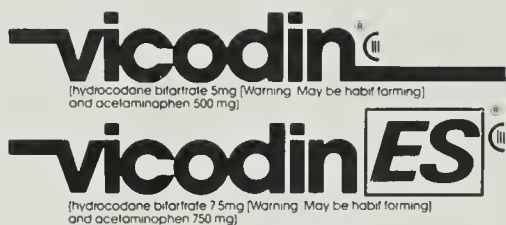
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2. Standard industry new prescription audit.

Please see adjacent page for brief summary of prescribing information.



INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS:

Allergic-Type Reactions: VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy:

Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

Labor and Delivery: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

Gastrointestinal System: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

DRUG ABUSE AND DEPENDENCE:

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution.

OVERDOSAGE:

Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised June 1989

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Board of Medicine Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Syed Arif Ahmed, MD, 2360 Van Dyke, Marlette, MI 48453

Action, Date Taken: Revoked, Fined \$250,000; May 17, 1990

Reason: Negligence-Incompetency

Name: Shams Husain Arastu, MD, 2116C Tennessee Circle, Loring AFB, ME 04751

Action, Date Taken: Probation 18 months, Reprimand; June 15, 1990

Reason: Negligence-Incompetency

Name: Jayantilal J. Bathani, MD, 509 Haxen St., Paw Paw, MI 49079

Action, Date Taken: Summary Suspension, July 18, 1990

Reason: Conviction/Violation of Penal Code

Name: George S. Beard, MD, Route 1 Box 134-A, Fairground Road, US 60 East, Hardinsburg, KY 40143

Action, Date Taken: Suspended 6 months; March 21, 1990

Reason: Drug Related

Name: Dale Dudley, MD, 18254 Liver-
nois, Detroit, MI 48033

Action, Date Taken: Revoked, Fined \$50,000; June 18, 1990

Reason: Conviction-Drug Related

Name: Thomas G. Hicks, MD, 575 Indian Hills Dr., Hastings, MI 49058

Action, Date Taken: Limited License 3 year min., Probation 3 years, Fined \$1,500, Reprimand; June 15, 1990

Reason: Substance Abuse

Name: Gamat Amin Isaacs, MD, 3220 S. Pennsylvania, Suite 3, Lansing, MI 48910

Action, Date Taken: Probation 1 year, Reprimand; April 20, 1990

Reason: Mental-Physical Incompetency

Name: Larry L. Kompus, MD, 4166 Stod-
dard, Orchard Lake, MI 48033

Action, Date Taken: Summary Suspension, April 18, 1990; Reinstated-Reversal of Stay from Court of Appeals; June 1, 1990

Reason: Drug Related

Name: John Mark Lowenbergh, MD, 900 Wall St., Ann Arbor, MI 48105

Action, Date Taken: Reprimand/Fine: \$1,000, Probation: 2 years, Earn 100 credit hours in addition to the 150 hours mandated for license renewal

Reason: CE Audit Violation

Name: Herbert L. Malinoff, MD, 2799 West Grand Blvd., Detroit, MI 48202

Action, Date Taken: Summary Suspension; April 18, 1990

Name: Hina B. Papo, MD, St. Joseph Mercy Hospital, Box 995, Ann Arbor, MI 48106

Action, Date Taken: Probation 18 months, Fined \$1,000, Reprimand; May 18, 1990

Reason: Drug Related

Name: Michael J. Peters, MD, 2196 Wy-
cliffe, West Bloomfield, MI 48033

Action, Date Taken: Reprimand, Fined \$1,000, Probation 2 years, Earn 100 addition CME credits; May 15, 1990

Reason: Non-Compliance CE Requirement

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

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Jackson 49201

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4990 Clark Rd. #400
Ypsilanti 48197

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802 W. King St.
Owosso 48867

Neil H. Alperin, MD — RHU/IM
11012 E. 13 Mile Rd. #103
Warren 48093

Atul C. Agrawal, MD — GS
729 W. Trescott Box 126
Harbor Beach 48441

Richard J. Ashack, MD — D
426 Michigan Ave., NE
Grand Rapids 49503

George E. Bacon, MD — PD/PDE
100 Michigan, NE #41
Grand Rapids 49503

Susan E. Barlow, MD — EM
1900 Columbus Ave.
Bay City 48708

Kenneth A. Beil, MD — DR
730 Beechwood Dr.
Niles 49120

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1439 Burgundy Rd.
Ann Arbor 48105

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905 John St.
Kalamazoo 49001

Iqbal G. Boxwala, MD — IM/OM
6127 Silverbrooke Villa, West
West Bloomfield 48322

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5301 E. Huron River Dr.
Ann Arbor 48106

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4834 Atkins Rd.

Vassar 48768

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Medical Park
Iron Mountain 49801

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395 South Shore Dr. #308
Battle Creek 49015

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Community Hospital
Battle Creek 49016

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Kalamazoo 49001

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Sturgis 49091

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Saginaw 48603

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DEATHS

James R. Bowlby, MD *Livonia*

James R. Bowlby, MD, a clinical cardiologist, died May 29. He was 62. Doctor Bowlby graduated from Wayne State University School of Medicine in 1953. After serving in the Army Medical Corps in 1955 and 1956, Doctor Bowlby completed his residency in internal medicine at Detroit Receiving Hospital. He enjoyed being a team physician for several Livonia school athletic teams. Doctor Bowlby retired from his practice earlier this year because of poor health. He was affiliated with St. Mary Hospital for more than 30 years, specialized in clinical cardiology and was a former chief of staff at St. Mary Hospital. He was a fellow of the American College of Physicians, an associate fellow of the American College of Cardiology, a member of the Wayne County Medical Society and MSMS.

Ennis H. Corley, MD *Arizona*

Ennis H. Corley, MD, a general surgeon, died May 17. He was 92. Doctor Corley served as Chief of Surgery at Mercy Hospital and W.A. Foote Memorial Hospital. He practiced medicine for 42 years in Jackson, retiring in 1972. Early in his practice he served as the physician for the Health Department and for the State Prison of Southern Michigan. He was a member and past president of the Jackson County Medical Society, a member of the American Medical Association, the American College of Surgeons and MSMS.

Conrad R. Lam, MD *Farmington Hills*

Conrad R. Lam, MD, a general surgeon, died May 14. He was 84. Doctor Lam graduated in 1927 from Simmons University, now Hardin-Simmons University, and received his doctorate of medicine from Yale in 1932. He served his internship at Henry Ford Hospital. A staff member at Henry Ford for more than five decades, Doctor Lam retired in 1970 as chief of the Division of Thoracic Surgery. He performed Michigan's first open heart operation in 1956 at Ford Hospital in Detroit, which involved the state's first total heart-lung bypass. He was the first in the United States to use heparin. He was considered a medical innovator and helped make Henry Ford Hospital known nationally and internationally. He was co-author of the book, *Esophageal Hiatus Hernia* and also wrote more than 200 journal articles and book chapters. He was a founding member of the Central Surgical Association, a member of the American Association for Thoracic Surgery, a fellow of the American

Surgical Association and a member of MSMS.

Charles W. McColl, MD *Rochester Hills*

Charles W. McColl, MD, a general practitioner, died June 12. He was 79. Doctor McColl graduated from the University of Michigan in 1932 and Western Reserve University School of Medicine in 1937. He served his internship at Highland Park General Hospital and his residency at Port Huron Hospital. He was on the staff of Wyandotte General Hospital. Doctor McColl was a member of the Academy of General Practice and MSMS.

James M. Pierce, Jr., MD *Detroit*

James M. Pierce, Jr., MD, a urologist, died June 12. He was 63. Doctor Pierce received his medical degree from the University of Cincinnati College of Medicine followed by an internship and residency in surgery at University Hospital in Ann Arbor. He then performed a fellowship at Harvard followed by

a residency in urological surgery in Ann Arbor. His hospital affiliations included Detroit Receiving, Veterans Administration Medical Center in Allen Park, Hutzel and Children's Hospital of Michigan. He came to Wayne State University as an assistant professor in 1958 and was named professor and chairman of the department of urology in 1963. Doctor Pierce was recently appointed as the Dr. Donald J. and Dorothy Jaffar Endowed Professor in Urology, one of the highest honors a university can bestow on a member of its faculty. The appointment recognizes exceptional scholarly achievement in the field of urology. He also assisted in the nation's first kidney transplant in 1954 and performed the first in Michigan in 1968. He also worked on the Harvard Medical School team that built the first kidney dialysis machine. He was a member of several organizations including the American Association of Genito-Urinary Surgeons, the American Association of University Professors, the Michigan Kidney Foundation, MSMS, Wayne County Medical Society, and the Society of University Urologists, of which he served as president from 1981-83.

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	\$100,000	\$250,000	\$500,000
Under 30	\$ 3.33	\$ 8.35	\$ 16.65
30	\$ 4.66	\$11.65	\$ 23.30
35	\$ 7.33	\$18.35	\$ 35.07
40	\$13.21	\$20.13	\$ 35.94
45	\$15.68	\$23.58	\$ 42.43
50	\$17.86	\$33.34	\$ 62.35
55	\$22.34	\$48.69	\$ 90.73
60	\$32.48	\$74.69	\$145.06

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

September

12, New Developments in the Care of AIDS Patients. **Location:** Henry Ford Hospital – E & R Bldg. #2055, Detroit, Michigan. **Sponsor:** Henry Ford Hospital, Office of Medical Education. **Contact:** Shelley L. Helton, Office of Continuing Medical Education, 2799 West Grand Boulevard, Detroit, MI 48202-2689. (313) 876-3073. **Approved for:** 4.25 hours Category I Credit.

12-14, Office Procedures for Primary Care Physicians. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School and Michigan Academy of Family Physicians. **Contact:** Towsley Center, Office of Continuing Medical Education, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 936-9800. **Approved for:** 12 and 16 hours Category I Credit.

18-24, Ongoing Seminar Series on "The Patient with Psychosomatic Complaints." **Location:** Fisher Building, Detroit, Michigan. **Sponsor:** Bar-Levav Educational Association. **Contact:** David Fogel, MD, Bar-Levav Educational Association, 200 Fisher Building, Suite 200, Detroit, MI 48202. (313) 872-7400. **Approved for:** 4 hours Category I Credit.

21-22, Recent Advances in Interventional Radiology & MRI. **Location:** Henry Ford Hospital – Buerki Auditorium, Detroit, Michigan. **Sponsor:** Henry Ford Hospital, Office of Medical Education. **Contact:** Shelley L. Helton, Office of Continuing Medical Education, 2799 West Grand Boulevard, Detroit, MI 48202-2689. (313) 876-3073. **Approved for:** 14 hours Category I Credit.

24-25, Urology Update 1990. **Location:** Novi Hilton, Novi, Michigan. **Sponsor:** William Beaumont Hospital, Department of Urology. **Contact:** Department of Urology, William Beaumont Hospital, 3601 W. 13 Mile

Road, Royal Oak, MI 48073. **Approved for:** 16 hours Category I Credit.

28, Eight Annual Update on Psychopharmacology. **Location:** Eleanor N. Dana Center, Toledo, Ohio. **Sponsor:** Medical College of Ohio. **Contact:** Susan Hahn, Office of Continuing Medical Education, Medical College of Ohio, P.O. Box 10008, Toledo, OH 43699-0008. (419) 381-4237. **Approved for:** 6 hours Category I Credit.

October

1-2, Update on Pulmonary and Critical Care Medicine. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 14 hours Category I Credit.

3, HFH Diabetes Symposium: Primary Care & Sub-specialty Management of Diabetes Mellitus. **Location:** Fairlane Manor, Dearborn, Michigan. **Sponsor:** Henry Ford Hospital, Office of Medical Education. **Contact:** Shelley L. Helton, Office of Continuing Medical Education, 2799 West Grand Boulevard, Detroit, MI 48202-2689. (313) 876-3073. **Approved for:** 6.5 hours Category I Credit.

4-5, Critical Clinical Issues in the Care of the Elderly: Update on Geriatric Cardiology. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Geriatric Center. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 936-9800. **Approved for:** 12 hours Category I Credit.

5-6, Twelfth Annual Cardiology Seminar. **Location:** Clarion Hotel, Lansing Michigan. **Sponsors:** Ingham Medical Center, Department of Continuing Medical Education and Michigan State University, Department of Medicine. **Contact:** M.A. Taylor, Director, Office of Continuing Medical Education, Ingham Medical Center, Lansing, MI 48910-2819. (517) 334-2107. **Approved for:** 12 hours Category I Credit.

6, Controversies in Cardiology – 1990. **Location:** Novi Hilton, Novi, Michigan. **Sponsor:** American Heart Association of Michigan. **Contact:** Lori Hall, American

Heart Association of Michigan, 16310 W. 12 Mile Road, Lathrup Village, MI 48076. (313) 557-9500 ext. 343. **Approved for:** 6 hours Category I Credit.

10-12, A Symposium in Diabetes Care. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Registrar, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University Of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 936-9800. **Approved for:** 20 hours Category I Credit.

12, Basic Life Support for Health Professionals. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gwen Goldfarb, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 5 hours Category I Credit.

12-13, 14th Annual Michigan Fall Radiology Conference. **Location:** William Beaumont Hospital, Royal Oak, Michigan. **Sponsor:** William Beaumont Hospital-Diagnostic Radiology. **Contact:** Mary Anne Smith, Diagnostic Radiology, William Beaumont Hospital, 3601 W. 13 Mile Rd. Royal Oak, MI 48073. (313) 551-6064. **Approved for:** 14 hours Category I Credit.

13, Advanced Cardiac Life Support Recertification Course. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gwen Goldfarb, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 7 hours Category I Credit.

17, Legal and Ethical Responsibilities Toward the Terminally Ill Conference. **Location:** Wayne County Medical Society, Detroit, Michigan. **Sponsor:** Wayne County Medical Society. **Contact:** Alice Waite, Wayne County Medical Society, 1010 Antietam Rd., Detroit, MI 48207. (313) 567-1640. **Approved for:** 5 hours Category I Credit.

18, The Patient With an Automatic Implantable Cardioverter Defibrillator (AICD). **Location:** Eleanor N. Dana Center, Toledo, Ohio. **Contact:** Susan Hahn, Office of Continuing Medical Education, Medical College of Ohio, P.O. Box 10008, Toledo, OH 43699-0008. (419) 381-4237. **Approved for:** 3 hours Category I Credit.

MEETINGS

MSMS Meetings

September

14,15, MSMS/PSG, AMA's Starting Yourself in Medical Practice: Selecting an HMO or Private Practice, Hyatt Regency, Dearborn, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

18, MSMS Leadership Conference, Radisson Hotel, Lansing, MI. Contact: Mary Anne Ford, Chief, State Government Affairs (517) 337-1351.

19, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

19, MSMS 1990 Risk Management Seminar, Hyatt Regency, Flint, MI. Contact: Jeanne Miller, Departmental Secretary (517) 337-1351.

27, MSMS 1990 Risk Management Seminar, Marriott Inn, Ann Arbor, MI. Contact: Jeanne Miller, Departmental Secretary (517) 337-1351.

October

3, MSMS/PSG, Health Law Update, Hyatt Regency, Dearborn, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

3,4, MSMS/PSG, Third Party Reimbursement, (3rd) - Hyatt Regency, Dearborn, MI. (4th) - Amway Grand, Grand Rapids, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

9,10,11, MSMS/BCBS Medicare, (9th) - Amway Grand, Grand Rapids, MI. (10th) - To be announced, Bay City, MI. (11th) - Weber Inn, Ann Arbor, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

10, MSMS 1990 Risk Management Seminar, Amway Grand Plaza, Grand Rapids, MI. Contact: Jeanne Miller, Departmental Secretary (517) 337-1351.

17,18, MSMS/PSG, Retirement Planning, (17th) - Hyatt Regency, Dearborn, MI. (18th) - Amway Grand, Grand Rapids, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

23,24,25, MSMS/PSG, Advanced Coding, (23rd) - Dearborn Inn, Dearborn, MI. (24th) - To be announced, Lansing, MI. (25th) - Bay Valley Inn, Bay City, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

25, MSMS 1990 Risk Management Seminar, Holiday Inn, East Lansing, MI. Contact: Jeanne Miller, Departmental Secretary (517) 337-1351.

31, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

November

6,7,8, MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, MI. Contact: Sherry L. Fent, Chief, Physician Education (517) 337-1351.

13-16, MSMS/PSG/AMA, Office Staff Training, Hyatt Regency, Dearborn, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

AMA Meetings

October

11-12, Ninth Annual AMA Science Reporters Conference. Contact: John Hammarley (312) 645-4417.

Michigan Specialty Society Meetings

September

13, Michigan Psychoanalytic Society, Psychoanalysis and Psychotherapy; A Contemporary Perspective. Contact: John J. Hartman, Chairman (313) 559-5855 or (313) 557-8633.

October

11,18,25, Michigan Psychoanalytic Institute Discussion Series for Parents; Mid-Childhood. Contact: Michigan Psychoanalytic Institute, Extension Division (313) 559-5855.

25, Michigan Psychoanalytic Society, Freud and Canard Ferdinand-Meyer. Contact: John J. Hartman, Chairman (313) 559-5855 or (313) 557-8633.

November

8,15,29, Michigan Psychoanalytic Institute Discussion Series for Parents; Adolescence. Contact: Michigan Psychoanalytic Institute, Extension Division (313) 559-5855.

17, Michigan Psychoanalytic Society, Sixteenth Annual Symposium; Perversion and Object Relations; Sexual Misuse of Persons. Contact: John J. Hartman, Chairman (313) 559-5855 or (313) 557-8633.

National Specialty Society Meetings

September

16-19, American College of Emergency Physicians - Annual Meeting, San Francisco, CA. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

21-23, Society of Thoracic Surgeons; Interim Meeting, Chicago, IL. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

21-26, American College of Radiology; Annual Meeting, Nashville, TN. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

October

5-10, American Academy of Pediatrics; Annual Scientific Meeting, Boston, MA. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

6-8, American Academy of Family Physicians; Congress of Delegates, Dallas, TX. Contact: Beth Paulsen, Manager (800) 274-2237 ext. 4220.

7-11, American Academy of Family Physicians; Scientific Assembly, Dallas, TX. Contact: Beth Paulsen, Manager (800) 274-2237 ext. 4220.

7-12, American College of Surgeons; Annual Clinical Congress, San Francisco, CA. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

8-11, American Academy of Family Physicians; Annual Meeting, Dallas TX. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

20-25, Congress of Neurological Surgeons; Annual Meeting, Los Angeles, CA. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

20-26, College of American Pathologists; Annual Fall Meeting, Dallas, TX. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

Other Meetings

September

24-25, Fifth Annual Urological Postgraduate Course. Contact: Ananias C. Diokno, MD, William Beaumont Hospital (313) 288-2554.

CLASSIFIEDS

The rate for classified advertising in *Michigan Medicine* is 80 cents per word, with a minimum charge of \$40.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

POSITIONS OPEN

AMERICAN/SCI, INC. a local healthcare consulting firm is currently assisting several Michigan clients with the following opportunities: **OB/GYN...** Opportunity to join well-established group of six in beautiful Northern Michigan Community. **Pediatrics...** Well-established group of two in Grand Rapids area searching for third. **Internal Medicine...** Group of eight searching for additional general internist, beautiful Northern Michigan community on Lake Michigan. **Urgent Care...** 13,000 visits per year \$45.00 an hour, full benefits and malpractice, located in Canton. **Orthopedic Surgery...** Group of two searching for third, beautiful Western Michigan community on Lake Michigan. **Family Practice...** Small Northern Michigan community seeks a Family Practitioner to join a growing partnership. **Emergency Medicine...** \$65 to \$90 an hour, 48,000 visits per year, paid malpractice, full benefits, Metro Detroit. For further information contact: Jim Lucas, director, physician recruitment, 2075 W. Big Beaver Rd., Suite 600, Troy, MI 48084 (313) 649-2010.

DERMATOLOGIST, PSYCHIATRIST, ALLERGIST, INTERNAL MEDICINE, FAMILY PRACTICE — A progressive 126-bed, two-hospital system is seeking the above specialties to establish practices in the Iron Mountain area of Michigan's Upper Peninsula. Must have BE/BC. Located 100 miles north of Green Bay, Wisconsin, Dickinson County Hospitals has a medical staff of 45 full-time physicians and a total service area population of over 45,000. Diagnostic capabilities include a CT scanner, CO2 laser, and a fully-staffed special diagnostic department. CONTACT: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, MI 49801 (906) 779-4500.

EMERGENCY PHYSICIANS Port Huron area. Low volume, 10,000 to 12,000 annual visits. Twelve or 24-hour shifts. Salary or hourly. Send CV to Joseph L. Romain, 18161 West 13 Mile Road, Suite A-2, Southfield, MI 48076 or call (313) 642-9878.

EMERGENCY PHYSICIAN position available for Board Certified or Emergency Medicine Residency Trained Physician for suburban Detroit teaching hospital. Fee for service with a minimum guarantee of \$75/hr. Partnership available. Please send CV to P.O. Box 2770, Southfield, MI 48037 or call (313) 642-9893.

FAMILY PRACTICE – HOSPITAL-SPONSORED clinic opportunity. Dynamic, growth-oriented hospital in beautiful North Central

Wisconsin is seeking two family physicians for a new clinic facility currently being constructed. The administrative burdens of medical practice will be minimized in this hospital-managed clinic. The hospital has committed to an income and benefit package which is significantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus, and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact Dan McCormick, president, Allen McCormick, France Place, Suite 920, 3601 Minnesota Drive, Bloomington, MN 55435. (612) 835-5123.

FAMILY PRACTICE MINNESOTA – Physician needed for **employment** or **ownership** of broad based practice in rural community 45 minutes south of metro area. Existing shared call, tremendous earning history of retired physician, fully-equipped and staffed office. Near outstanding hospital with all specialties represented. Guaranteed compensation, full benefits, bonus. For this and other opportunities in the Upper Midwest, send CV to: Mary Jo Cordes, MDsearch, P.O. Box 21507, Saint Paul, MN 55121. Call Collect (612) 454-7291.

FULL-TIME, PART-TIME, AND LOCUM TENENS. GPs, PPs, and **Emergency Physicians** needed to staff a network of convenience medical care centers located in Bay City, Saginaw, Midland, and Mt. Pleasant, Michigan. Flexible hours and attractive compensation packages. Send CV to or contact Euclid Medical Group, PC, 1420 Center Avenue, Bay City, MI 48708 (517) 892-1199.

GASTROENTEROLOGIST WANTED – Florida – Terrific medium-sized coastal town. Two personable solo American GE's seeking same to share heavy case load and coverage. Mail CV to Richard Libby, 5510 Montgomery St., Chevy Chase, MD 20015.

GAYLORD / WEST BRANCH AREA: Full-time **EMERGENCY Department** positions available at moderate volume facilities located in beautiful Northern Michigan. Hourly compensation and malpractice insurance provided. Benefit package available to full-time physicians. Contact: Betty Looze, Emergency Consultants, Inc., 2240 S. Airport Rd., Room 23, Traverse City, MI 49684. (800) 253-1795 or in Michigan (800) 632-3496.

GRAND RAPIDS: BE/BC **Family Physician** sought for FP group in Grand Rapids. Private, fee for service practice offers competitive income and benefits. For additional information contact Greg Peterson, The Peterson Group, 8700 Monrovia, Suite 310, Shawnee Mission, KS 66215 or call (800) 669-4804. INQUIRIES KEPT IN STRICTEST CONFIDENCE.

GRAND RAPIDS: Progressive, established group of residency-trained, board-certified **emergency physicians** seek additional mem-

ber. Must love emergency medicine and have sense of humor. Group has excellent practice of six years in newly-renovated department in 350-bed hospital. Full departmental status with excellent relationship with medical staff. Transcribed dictated charts and computer information systems in the department. Patient volume is 32,000. We have a high degree of participation in EMS system and also teach residents in the ED with house staff in all specialties except EM and PEDS. The initial compensation is over \$125,000. Malpractice, health, and disability insurance as well as \$2,000 education allowance the first year. Progressive community with arts and cultural opportunities. Beach, water, fishing, hunting, and outdoors activities. Send CV or contact: William C. Doney, MD, FACEP, chairman, Department of Emergency Medicine, Saint Mary's Health Services, 200 Jefferson SE, Grand Rapids, MI 49503 (616) 774-6789.

INTERNAL MEDICINE, OB/GYN, FAMILY PRACTICE: Opportunities available for BC/BE physicians to join independent, multi-specialty group with 10 clinics in the Minneapolis/St. Paul metropolitan area. Fee-for-service and pre-paid patients, highly competitive earnings, excellent benefit package. Reply: Nancy Borgstrom, Aspen Medical Group, 1020 Bandana Boulevard West, St. Paul, MN 55108 (612) 641-7185.

INVASIVE CARDIOLOGIST – Four-physician, single specialty cardiology group has an **immediate opening** for a BE/BC invasive cardiologist. Fully-equipped cardiovascular labs are expanding and an excellent cardiovascular surgery program is established. The practice serves a large and expanding regional referral area in Mid-Michigan. Generous compensation and early partnership are available. Send CV to: The Heart Group, PC, Attn: N. Polzin, 4701 Towne Centre Road, Suite 201, Saginaw, MI 48604.

LAPEER: Seeking full-time and part-time **emergency department physicians** for busy 164-bed hospital. Residency training in emergency medicine or primary specialty required. Excellent compensation and attractive schedule. Malpractice insurance provided. Benefit package available to full-time physicians. Contact: Betty Looze, Emergency Consultants, Inc., 2240 S. Airport Rd., Room 23, Traverse City, MI 49684. (800) 253-1795 or in Michigan (800) 632-3496.

LIFESPAN HEALTH CARE SERVICES seeks **Family Physicians** for: Cambridge, MN...Crosby, MN...Grantsburg, WI...Hopkins, MN...Lakefield, MN...Litchfield, MN...Minneapolis, MN...Monticello, MN...Springfield, MN...St. James, MN...Wayzata, MN...Woodville, WI...For further information, contact: LifeSpan Health Care Services, 800 East 28th. Street, Minneapolis, MN 55407 or call Jerry Hess (612) 863-4193.

CLASSIFIEDS

MICHIGAN: Emergency Room Physicians – full or part time in Southwest Michigan. Competitive reimbursement, health insurance (full time). Beautiful area with abundant cultural and recreational opportunities. Please send CV to Southwestern Michigan Emergency Services, PC, 4341 S. Westnedge, Suite 1112, Kalamazoo, MI 49008 or call (616) 343-3900.

MICHIGAN, GREATER DETROIT AREA: Looking for career-oriented **emergency physicians** board certified/prepared in emergency medicine, internal medicine, surgery or family practice. Directorships with stipends available. Outstanding compensation including malpractice insurance. Benefit package available to full-time physicians. Contact: Sondra Hefflebower, Emergency Consultants, Inc., 2240 South Airport Road, Room 23, Traverse City, MI 49684 call (800) 253-1795 or in Michigan (800) 632-3496.

MICHIGAN, SOUTHWEST: PHYSICIAN FOR EMERGENCY SERVICES. Community Emergency Departments, urgent care center, physician staffed helicopter. Board eligible or certified in emergency medicine/internal medicine/family practice/general surgery or appropriate emergency medicine experience. Competitive salary and benefits. Excellent recreational area with abundant cultural opportunities. Send CV to Kalamazoo Emergency Associates, PC, 6600 S. Westnedge #101, Portage, MI 49002. May contact Lisa Semon (616) 329-3200.

NEW YORK: Finger Lake Region – Seeking **Director** and full-time **emergency department physicians**. Excellent compensation, paid malpractice insurance, signing bonus, and optional benefit package. Contact: Karen Remai, Emergency Consultants, Inc., 2240 South Airport Road, Room 23, Traverse City, MI 49684. (800) 253-1795 or in Michigan (800) 632-3496.

NON-INVASIVE CARDIOLOGIST – Four-physician, single specialty cardiology group has an immediate opening for a BE/BC non-invasive cardiologist. Echo, doppler, holter, and treadmill are established in-clinic. Full invasive and surgical programs are established. The practice serves a large and expanding regional referral area in Mid-Michigan. Generous compensation and early partnership are available. Send CV to: The Heart Group, PC, Attn: N. Polzin, 4701 Towne Center Road, Suite 201, Saginaw, MI 48604.

OB-GYN / OTOLARYNGOLOGY / ORTHOPEDICS / CARDIOLOGY / FAMILY PRACTICE / PEDIATRICS / INTERNAL MEDICINE / GENERAL SURGERY: Several attractive opportunities in *Wisconsin, Michigan, and Indiana* (many on lakes) for BC/BE physicians. Contact Bob Strzelczyk to discuss your practice requirements and these positions. **Strelcheck & Associates, Inc.**, 12724 N. Maplecrest Lane, Mequon, WI 53092, (800) 243-4353.

OHIO (NORTHEAST AND CENTRAL LOCATIONS): Full-time opportunities for career oriented **EMERGENCY DEPARTMENT PHYSICIANS**. Directorships available. Attractive, moderate volume facilities. Competitive hourly rates, malpractice insurance and flexible scheduling. Benefit package available to full-time physicians. For more information contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 23, Traverse City, MI 49684 (800) 253-1795 or in Michigan (800) 632-3496.

OPPORTUNITIES for Doctors of Medicine are available in: **Family Practice, Internal Medicine, Ob/Gyn, Pediatrics, Occupational/Industrial Medicine**. Join one of DMC Health Care Centers' multi-specialty, full service facilities conducive to efficient, quality patient care in Western Wayne County, Oakland County, and Macomb County. Competitive compensation and benefits. Opportunities to supplement base income in weekend and evening Urgent Care. An affiliate of The Detroit Medical Center and an equal opportunity employer. Contact Karen Safko, Chief Operating Officer, 41935 W. Twelve Mile Rd., Novi, MI 48377 or call (313) 347-8010.

ORTHOPEDIC SURGEON – A progressive 126-bed, two-hospital system is seeking an orthopedic surgeon to join an established practice in the Iron Mountain area of Michigan's Upper Peninsula. Must have BE/BC. Dickinson County Hospitals has a medical staff of 45 full-time physicians and a total service area population of over 45,000. Doctor Roberts will guarantee \$250,000 plus malpractice insurance, office space, CME, vacation and relocation expenses. CONTACT: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, MI 49801 (906) 779-4500.

PEDIATRICIAN: 115-physician multi-specialty clinic in the Fox River Valley of northeastern **Wisconsin** desires a BC/BE pediatrician to join department of 17 BC/BE pediatricians. Two-year guarantee plus comprehensive benefit package offered. The community offers a superb recreational, cultural, and family environment in which to practice. For information please call or write: Roger Rathert, MD, La Salle Clinic, 411 Lincoln Street, Neenah, WI 54956 (414) 727-2702.

PHYSICIANS WANTED: Bloomfield, IA., a community of 2,850 has long been well known for its leadership in Rural Health Care currently needs two **Family Physicians** and an **Internal Medicine Specialist**. Outstanding opportunities are available to put your skills to work in this community, which draws patients from a 50-mile radius. You will enjoy the clean living, low cost housing and high income potential. Share work and call (approximately 1 day/week) with other Family Physicians and Specialists. Currently the local hospital is served by two General Surgeons, Orthopedic Surgeon, FP,

GP, Internal Medicine/Cast., Ophthalmologist and Urologist. An array of other Specialists rotate in the Community one to two days per month. An excellent compensation package including a multi-year guarantee awaits you. Bloomfield has been approved for a Federal Loan Repayment Program, which will forgive up to \$80,000 in Medical Education Loans. If you are interested in providing Quality Personal and Professional Medical Care to the patients in our large Service Area, you should be interested in sending your CV to: Dick Early, CRNA, Recruitment Chairman, P.O. Box 54, Bloomfield, IA 52537. For more detailed information, please call collect: Lorrie Bailey, at (515) 664-2357.

PHYSICIAN WANTED: Enthusiastic **General Practitioner** or **Internist**, full-or part-time, may be semi-retired. Days only. Southfield area doctor's office/walk-in care facility. Call Mr. Corey days: (313) 557-5155, evenings: (313) 661-0404.

PRIVATE PRACTICE OPPORTUNITIES exist in Southern Indiana affiliated with a 590-bed hospital. Specialties include **Internal Medicine** and **Family Practice**. Competitive compensation plan and attractive partnership arrangement available. Send CV to Don Hoit, 11222 Tesson Ferry Rd., Suite 203, St. Louis, MO 63123 or call (800) 336-3963.

RADIOLOGIST: A three-physician radiology group is seeking a fourth radiologist with experience and interest in interventional radiology. Dickinson County Hospitals is a progressive, 126-bed, two hospital system, located in Iron Mountain, Michigan's Upper Peninsula. We have a service area population of over 45,000. Contact and/or send resume: Doctors Specht/Shampo/Manzano, Radiology Department, Dickinson County Hospital, 400 Woodward Avenue, Iron Mountain, Michigan 49801 (906) 779-4565.

RADIOLOGIST: Sixth Board-Certified Diagnostic Radiologist needed for coverage at Marquette General Hospital (Regional Medical Center), private office, and two community hospitals. Practice includes: angiography and invasive procedures, Nuc Med, U/S, and GE CT and MRI. Marquette, Michigan is on the south shore of Lake Superior in the beautiful Upper Peninsula. There is immediate access to all outdoor activities: hunting, fishing, skiing, boating, etc. We offer competitive salary, early partnership, CME reimbursement, retirement plans and other fringes. Contact Marquette Radiology Associates, 1414 W. Fair, Marquette, MI 49855, or call Doctor Bert Lara (906) 225-3945.

RESIDENCY TRAINED, BOARD CERTIFIED, EMERGENCY PHYSICIAN to develop and direct a Residency Program in Emergency Medicine. Prior Administrative Experience in Academic Emergency Medicine necessary. Suburban Detroit Teaching Hospital. Excellent

Continued on next page

CLASSIFIEDS

Continued from previous page

Opportunity-Salary Open-Partnership Available. Reply with CV to P. O. Box 2770, Southfield, MI 48037.

WANTED: Full and Part-time **Primary Care Physicians** for urgent care walk-in clinics. Flexible hours, no hospital duties. Excellent compensation and incentives. Paid Malpractice Insurance. Full-time benefits include medical society dues, health, life and disability insurance. Send CV to: Outpatient Medical Clinics, P. O. Box 610948, Port Huron, MI 48061.

PRACTICES FOR SALE

APPRAISALS AND EVALUATIONS. We specialize in determining the value of practices for any purpose — sale, purchase, buy-in, buy-out, financial planning, divorce, etc. We also specialize in partnership development and practice analysis. Protect your interests! Call Richard Corey, CMDC, Medical-Dental Management Consultants Corp., 31158 Perrys Crossing, Farmington Hills, MI 48331. Call day (313) 661-0888 or night (313) 661-0404.

FORT WAYNE, INDIANA: FAMILY PRACTICE for sale. Thriving practice with mostly

young families located in newly-remodeled office next to 750-bed hospital; annual malpractice, \$4,113 (including obstetrics); equipment five years old or less; computerized accounts and billing; must leave practice for family reasons. Reply to: Katie Baeversstad, MD, 2016 Forest Park Blvd., Ft. Wayne, IN 46805 (219) 426-1579.

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PRESIDENT'S PAGE

When it comes to health insurance, MSMS members have many lessons to learn

By Susan H. Adelman, MD



One of the most hotly debated items at the 1990 MSMS House of Delegates was the health insurance policy offered to MSMS members through BCBSM. What was the problem? It is too expensive.

On the one hand, we in the medical society spend an inordinate amount of time trying to explain why US health care costs are rising and why purchasers of health care should stop complaining so much about their costs. Quality is what matters, we say. We in the US have the highest quality health care in the world; it is well worth the price. When it comes to our own health care costs though, just listen to us squawk.

Do we have to buy such a rich benefit package, we moan? Has our medical society ever solicited comparative bids? Why do we not have several different options available? I can get a cheaper package on my own. I do not care if it does not cover as much. My spouse and I do not need maternity care anymore. Why should we pay premiums through this group because somebody else needs maternity care? Why is it all so expensive, anyhow?

Perhaps there is a lesson to be learned here. There may be several. The gut issues at the 1990 MSMS House of Delegates were the cost of our health insurance, the dues increase, and resident work hours. What do these have in common? Two out of three of these are our current, intensely personal interests. The third is just as personal for our students and residents and

used to be vital for us when we were in training. We want the best health care coverage, but we do not want to pay for it any more than the general public wants to. We want shorter resident work hours, but we do not want our hospitals to pay for the extra costs involved, and residents do not want to pay by extending the length of their residencies to obtain a total training experience equivalent to what they could have obtained in a shorter time, with longer hours. We all want MSMS to do more for us, to be proactive, to conduct media campaigns to improve the physician's image, to lobby for us, to initiate and join in lawsuits on our behalf, to educate us, to communicate frequently with us, but we want no dues increase, despite continuing inflation.

Our nonmember colleagues tell us they have not joined because the medical society has not done enough for them, or it is ineffective. What they say is that they disapprove of something Doctor Sammons did at the AMA a year ago, or they do not like our stand on a certain issue. The truth is that they do not have to pay their dues to enjoy the benefits of everything we do on their behalf. In short, the bottom line is the bottom line. Perhaps we should not ask how many of these same nonmembers would be willing to blow the \$1,000 it would cost them in county-MSMS-AMA dues for one day in Las Vegas. What are their priorities? As for us, think how much lower *our* dues would be if 6,000 more physicians in Michigan paid *their* dues! But we digress.

Back to the cost of our MSMS health care coverage. We know that MSMS members are considered an undesirable health insurance group, from the standpoint of insurers. Why are doctors undesirable insureds? We are high utilizers. We know what we need and what we want. We know how to find the best. We know the newest tests, and we know how to obtain them. We also are older and more financially comfortable than the average insured. So we get the best, but when we see our bills, we start asking whether we really need the best.

Perhaps MSMS should ask all our

members what minimum coverage each of us wants and what is unnecessary, in our opinion. Then we will know what basic benefit package we as a profession should recommend for our patients. We then will have to acknowledge that all services not covered under this basic package should be offered as riders, for an additional charge to those patients who wish to buy them.

We also could analyze the coverage and the costs of the policies that our colleagues have purchased instead of ours, for themselves and their families. We will then know what members of the profession endorse with their own pocketbooks. This is what we must assure is the high-end prudent coverage package which we should recommend to our patients.

If our own overutilization, as patients, is the cause of our own high health care costs, doctors have another lesson to learn.

Our demand for health care, as the most knowledgeable patients of all, should represent the maximum amount of health care that US patients should demand. Furthermore, our personal health care costs should be the limit for per capita health care costs in the United States. If we want to know what percentage of the GNP that health costs actually should comprise, we may calculate it by extrapolating from our own costs.

In fact, this suggests that health care costs in the US may be too low. Business is preoccupied with the idea that physicians overtreat or overperform procedures in order to boost their own incomes. Physicians as patients, however, appear to demand even more services for themselves than they prescribe for their patients.

If we want to know how to identify and decrease overutilization, let us look at where we ourselves will accept less care. Suppose that the only way we could lower our own health care premiums with our present health insurance policies would be to cut utilization, where would we make the cuts? Think. The future of our health care system may depend on your answer.

Doctor Adelman is MSMS president.

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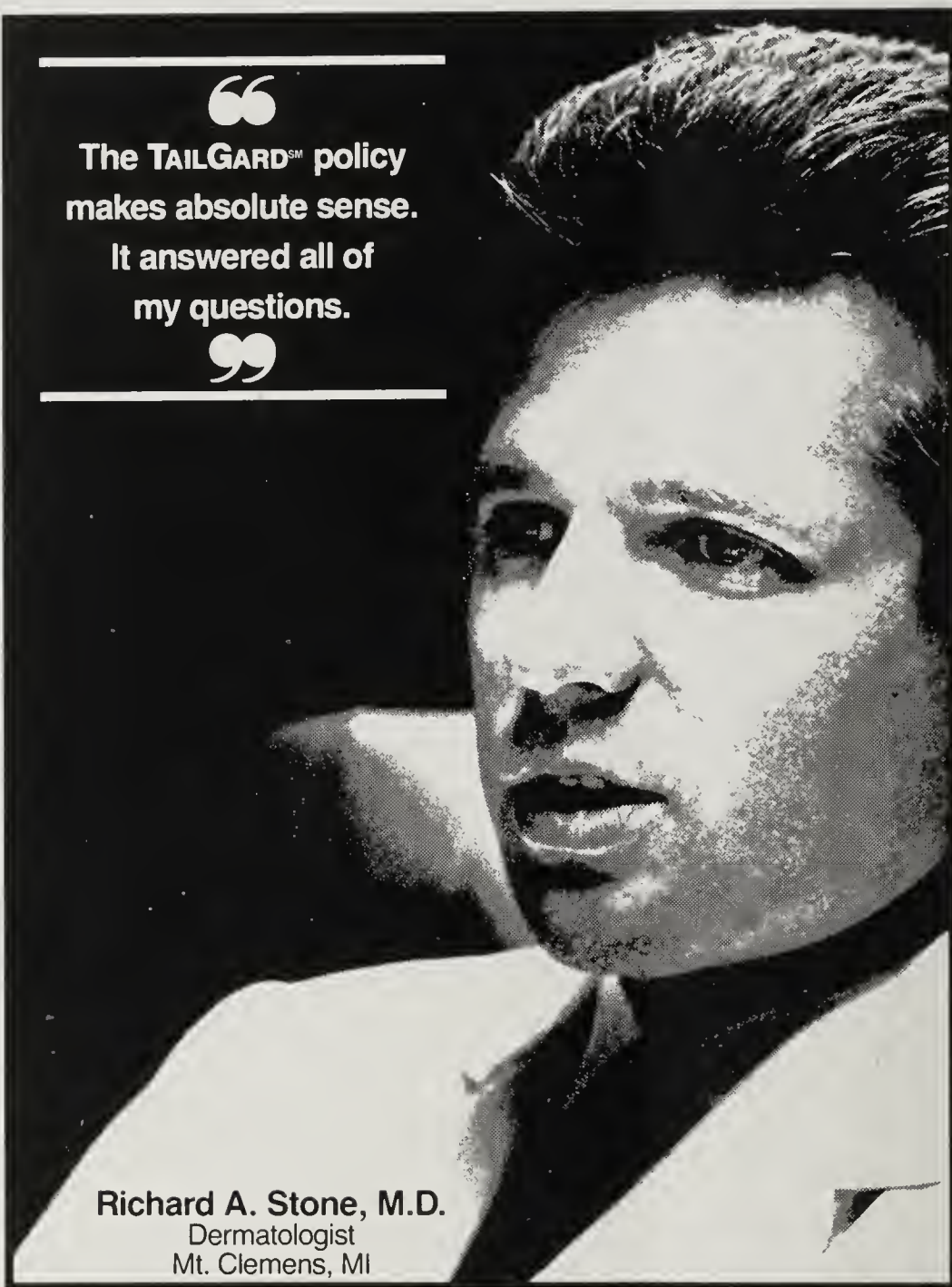
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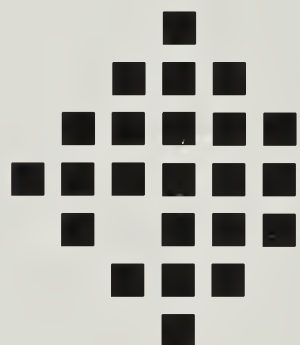
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14 COVER STORY

Cost containment, health care for the uninsured and professional liability are issues of key concern to Michigan physicians. Which Michigan gubernatorial candidate would best address these issues if elected next month? Michigan Medicine asked each of the candidates — Democratic candidate James J. Blanchard and Republican candidate John Engler — to write on these topics to give MSMS members an informed choice at the polls. Each candidate also was asked to discuss his health care delivery priorities. We hope you find their responses interesting and informative.



Page 14

F E A T U R E S

22 MEDICAL RECORDS SUBPOENAS

MSMS legal counsel reports that "many attorneys are causing record copy companies to subpoena medical records without attaching an authorization or consent signed by the patient. This is unacceptable." This feature details what physicians should and should not do regarding medical records subpoenas.

— BY RICHARD D. WEBER

25 MEDICAL INQUIRER FACTSHEET

This is the first in a series of inserts prepared by the MSMS Department of Medical Economics and Health Care Delivery featuring data and trends affecting Michigan physicians. Readers are encouraged to tear it out and save it for handy reference.

29 MICHIGAN HEALTH CARE DATA CORPORATION

A profile of the Michigan Health Care Data Corporation, the first and only statewide voluntary health data system in the US.

— BY GILBERT B. BLUHM, MD and JULIE LESTER

34 DISPOSITION OF A MEDICAL PRACTICE

Guidelines for selling or closing a medical practice.

39 VIEWPOINT: STATE LAW AND GRADUATE MEDICAL EDUCATION

— BY GERALD H. MANDELL, MD

42 BOARD OF MEDICINE ACTIONS



Page 22

D E P A R T M E N T S

5 In My Opinion

"MSMS must exhibit extreme fiscal responsibility in the year ahead"

BY JAMES L. FENTON, MD

7 Letters

9 Newsfronts

10 Physicians in the News

46 New Members

48 Deaths

50 Category I Courses

53 Meetings

56 Classifieds

59 Advertising Index

60 President's Page

"A creative partnership between practicing physicians and local health departments could help everyone"

BY SUSAN H. ADELMAN, MD



Page 34

In next month's issue of *Michigan Medicine*:
MSMS membership, plus the MSMS Annual Scientific Meeting official program.

Cover illustration by: Robert L. Brent.



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References

1. *USP DI Update*, September/October 1988, p 120.
2. *Br J Clin Pharmacol* 1985;20:710-713
3. *Data on file*, Lilly Research Laboratories.
4. *Scand J Gastroenterol* 1987;22(suppl 136):61-70.
5. *Am J Gastroenterol* 1989;84:769-774.

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Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given

an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H₂-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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IN MY OPINION

MSMS must exhibit extreme fiscal responsibility in the year ahead

By James L. Fenton, MD



The MSMS House of Delegates voted in May to raise our annual dues for 1991 by \$90 to \$440 per year. This action came following a recommendation from the Ways and Means Committee of the House and support by our treasurer and the Finance Committee of the Board of Directors.

It is no surprise to any of us that costs and expenses are continuing to rise. Just as our practice costs rise annually, so too are the expenses of operating the Michigan State Medical Society. In order to provide the existing necessary services to our membership, the House voted to raise our dues.

However, it is incumbent upon the officers, board of directors and staff members of MSMS to carefully review the budget for any evidence of fat, unnecessary items, unproductive services and/or frills. We owe this to our membership and we must prepare a lean-spartan budget for this next year.

Your leadership must remember that your bank account does not represent a bottomless pit. We must not plan to go to the well again, and again. New programs must be very carefully studied and evaluated before consideration of possible implementation. All existing programs should be reviewed annually and sunset if

not appropriate. MSMS programs which are not efficient or are non-productive should be immediately terminated. There is no room for pet projects, nor pork barrel in our budget.

In my opinion, the MSMS budget must be contained, if not reduced. We should not have a planned dues increase every three years. The Board of Directors should balance each budget and no expenditure should be allowed to go unchallenged. There will be no AMA-type financial problem in Michigan.

MSMS must remain viable, vigorous and effective in order to provide urgently needed member services. This still can be done with a cost-conscious Board directing an efficient staff. Membership will be retained following this dues increase only as long as leadership is perceived to be keenly aware of the pressures on our member's finances.

As we prepare the 1990-91 budget, let your director know your concerns. Let us know what member services you want, and which items you consider to be frills and/or unnecessary. We need your input in order to have a leaner, more cost effective MSMS budget.

The Board of Directors must exhibit extreme fiscal responsibility in order to keep MSMS financially sound.

Doctor Fenton is a member of the MSMS Board of Directors and the MSMS Committee on Publications.

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The Financial Institutions Bureau needs your help in apprising consumers about a new law that requires credit services organizations to be licensed by the State. The law was intended to curb abuses such as failure to perform the service purchased and failure to inform consumers of their rights.

Effective May 25, 1990, the Credit Services Act requires companies that, for a fee or other consideration, offer to obtain an extension of credit for a consumer or improve the person's credit record or rating — or provide advice about either of the foregoing — to be licensed. These firms advertise assistance with credit record problems, but are distinguishable from a licensed debt management company which, for a fee, provides extensive services such as bill paying and counselling to get debtors back on their feet by managing their finances better. That is, the former try to fix the symptoms, the latter, the source of a person's financial problems.

Samples of (print) ads placed by individuals or organizations that may be covered by the Credit Services Act include:

"AAA Credit

Absolutely no one refused.
Loans for any purpose.
Credit problems solved.
We can help! Results guaranteed.
(800) - "

"Bad Credit?

Learn exactly how to fix your credit report
- get loans, credit cards, etc. Recorded message for details.
(900) - "

You can help us let consumers know that they should only deal with licensed firms. Print media, for example, could note that "Advertisers at { the appropriate heading } are required by state law to be licensed." All media could require inclusion of the license number in advertising accepted.

If you have questions about the Credit Services Act or ideas about other ways we can help consumers determine whether a firm is authorized to conduct these businesses in Michigan, please phone the Research and Urban Investment Division of the Financial Institutions Bureau at (517) 373-8674. Thank you for your assistance.

*Eugene W. Kuthy
Commissioner
Department of Commerce
State of Michigan*

Maryland group houses information related to medical problems of musicians

For several years the Medical and Chirurgical Faculty's library has maintained the Music Medicine Clearinghouse, a collection of reprints, books, and other items related to the medical problems of musicians. The main focus of activity has been gathering, organizing, and disseminating the growing literature of the field to interested physicians, musicians, and others.

The Clearinghouse sponsored lectures on music medicine at the last two annual meetings of the society. The Clearinghouse cooperates with related organizations in larger information management efforts such as the development of a national database and electronic mail service.

Since 1988 the Clearinghouse has functioned as an ad hoc committee, guided by an advisory board of physicians. Now we are going through the process of becoming a standing committee of Med-Chi, the Committee of Medicine and the Performing Arts, which will broaden the scope of our activities.

We would like to know whether your society has any committee or section concerned with performing arts medicine. If so, we would appreciate knowing the contact person's name and address for future networking possibilities. We would be pleased to help your society in their re-

sponding to inquiries about this exciting new medical field.

*John B. DeHoff, MD
Chairman
Music Medicine Clearinghouse
Advisory Board
Baltimore, MD*

Editor's note: Although MSMS has no such section, we print this letter to alert physicians with special interest to the existence of the Maryland group.

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MEDICAL NEWSFRONTS

INDEX

U-M filter removes drugs from blood during surgery and dialysis	9	Transplant Specialty Center receives UNOS approval	11
Migraine related to psychiatric disorders, Henry Ford reports	9	International symposium on fetus as patient to be held for first time in Michigan	11
Radio frequency energy used to heal heart without major surgery	10	Patients needed for study	12
Bon Secours establishes foundation	10		

U-M filter removes drugs from blood during surgery and dialysis

Experiments on animals have confirmed the effectiveness of a blood filter developed by a University of Michigan research scientist. The filter reduces the risk of drug-induced bleeding and other serious complications after open-heart surgery, kidney dialysis, organ transplants and other common medical procedures.

The filtration device, designed by Victor Yang, assistant professor of pharmaceuticals in the U-M College of Pharmacy, removes heparin from the bloodstream of patients undergoing circulatory bypass procedures.

According to Doctor Yang, dogs undergoing circulatory bypass with the U-M filter had blood heparin levels 50 percent lower than dogs used in identical procedures without the filter. While a control group of animals receiving intravenous protamine injections showed significant protamine-induced

drops in blood pressure, cardiac output, white blood cell counts and platelet counts, these effects were either not observed in experimental animals using the U-M filter or were observed only at insignificant levels.

Dogs were selected for the research, according to Doctor Yang, because they are particularly sensitive to protamine's side effects.

Doctor Yang uses a chemical process to bind protamine molecules to fibers from a standard kidney dialysis filter. The filter is inserted in the final section of the bypass apparatus at a point just before blood is returned to the patient. With the filter in place, according to Doctor Yang, large doses of heparin can be administered as blood enters the bypass equipment. As blood flows through the filter on its way out of the bypass equipment, positively charged protamine molecules in the U-M filter bind with negatively charged heparin molecules, removing heparin from the bloodstream.

"It gives physicians the benefits of heparinization during bypass procedures without the complications caused by either heparin or

protamine," Doctor Yang said.

Doctor Yang says the filter also can be used during kidney dialysis and plasmapheresis. The filter has other applications with external blood-oxygenation devices and with experimental artificial heart, lung and liver devices.

Doctor Yang's research was supported by grants from the National Institutes of Health and the Whitaker Foundation. The U-M Intellectual Properties Office has patented the blood filtration device.

Migraine related to psychiatric disorders, Henry Ford reports

As if migraine attacks weren't headache enough, researchers recently confirmed migraine sufferers have higher rates of certain psychiatric disorders as well.

In a study of more than 1,000 young adults, researchers at Henry Ford Hospital found that 60 percent of the study participants who had migraine headaches also suffered from either anxiety, depression or both.

Depending on the type of migraine, these individuals were two-and-one-half to six-and-one-half times more likely to suffer from those psychiatric problems than persons who didn't have migraine headaches.

"Persons with migraine also were more likely to experience panic attacks, obsessive compulsive behaviors and phobias," according to Naomi Breslau, PhD, of the Departments of Psychiatry and Biostatistics and Research Epidemiology at Henry Ford Hospital. Breslau is principal investigator for the study.

"Migraine, anxiety and depression may simply be different expressions of the same underlying genetic vulnerability," said Glenn C.

Davis, MD, chairman of the Department of Psychiatry and co-principal investigator for the study. "Possibly, the neurochemistry that causes these disorders overlaps or is linked in some way we don't yet understand."

Although previous research hinted at a link between psychiatric disorders and migraine, this is one of the first studies to provide detailed data showing an association with depression and specific anxiety disorders. Doctor Davis and Breslau recently reported on the study at the International Association for the Study of Pain's VI World Congress on Pain in Australia.

The study also addresses the chicken and egg-style dilemma regarding which comes first: Migraine or psychiatric problems. While it may seem logical to assume the pain and stress of migraine trigger anxiety and depression, the facts don't support that premise. In approximately 70 percent of the persons with migraine who had psychiatric disorders, psychiatric symptoms (primarily anxiety symptoms) preceded the onset of migraine attacks, often by several years.

These data are the first to emerge from an epidemiologic study of 1,007 adults between the ages of 20 to 30. Called "Health and Adjustment in Young Adults," the study is investigating the underlying relationships between many different types of diseases.

Participants in the study were chosen randomly from the membership of Health Alliance Plan, a health maintenance organization. In compiling their data, researchers conducted structured interviews with each participant. Cases of migraine were identified using the definition of the disorder provided by the 1988 Ad Hoc Committee of the International Headache Society. Psychiatric

Continued on page 10

Continued from previous page

disorders were identified based on criteria established by the American Psychiatric Association.

Other findings from the study of migraine include:

- Of the 1,007 study participants, nearly 13 percent suffered from migraine, with common migraine slightly more prevalent than classic.
- Women are more than one-and-one-half times more likely to suffer from migraine than men.
- In comparison to women, men are younger when they experience their first migraine attack and they have a higher rate of remission.
- Migraine is inversely related to education. Individuals with a college education are far less likely to be affected by migraine than those with lower educational achievement.
- There is no difference in the prevalence of migraine between blacks and whites.

Radio frequency energy used to heal heart without major surgery

University of Michigan Medical Center cardiologists have developed a technique using radio frequency energy to treat two specific heart ailments without surgery or the need for a pacemaker.

Patients with various forms of tachycardia formerly required open heart surgery to repair the condition, says Fred Morady, MD, professor of internal medicine and director of the Medical Center's Clinical Electrophysiology Laboratory.

For the past eight months, U-M cardiologists have used the heat generated by radio waves to selectively cauterize specific areas inside the heart, safely removing the source of the irregular heartbeats without harming the heart or normal heart rate.

The U-M Medical Center is one of only a few institutions

in the nation using this technique, according to Doctor Morady.

"Using wires that are put in through a vein, we can get to the critical spot in the heart and deliver radio frequency energy — sort of like microwave energy to use a loose analogy," Doctor Morady says. "The tissue right at the end of the catheter is heated up and cauterized so we can selectively knock out the tachycardia and maintain the normal heart beats. So now these patients can be cured and they don't need a pacemaker, they don't need an operation and they don't have to take medication any more."

Bon Secours establishes foundation

Bon Secours of Michigan HealthCare System Inc., has established the Bon Secours Foundation, a subsidiary corporation which will enhance private support for Bon Secours Hospital and Bon Secours Nursing Care Center.

"Incorporated in January 1990, the foundation is the product of several years of consideration and many months of active planning by staff and volunteers," Vanu Bagchi, vice president for fund development, said. "Bon Secours now has a focused organization and a concise set of objectives to guide the development of private support for health care programs and projects."

"The foundation will be responsible for the investment and stewardship of philanthropic assets," David L. Barcus, director of fund development and executive director of the foundation, said. "The board of directors will oversee fundraising, grant applications, endowment fund investments and decisions on how contributed dollars will be spent."

John G. Martin, president and chief executive officer

Continued on page 11

Physicians in the News

Charles F. Whitten, MD, associate dean, Curricular Affairs, and professor of pediatrics, Wayne State University School of Medicine, has been named Distinguished Professor, an honorary title that recognizes an individual's excellence in a particular academic discipline. Doctor Whitten is well-known for establishing the University's Sickle Cell Center, one of only a few such centers in the country.

Elias A. Shaptini, MD, is president-elect of the American College of Occupational Medicine. Doctor Shaptini, vice-president of health and environment, American Natural Resources Company, Detroit, took office at the College's 75th annual business session held recently in Houston.

Ronald M. Benson, MD, has been elected president of the Michigan Psychoanalytic Institute for a three-year term. Doctor Benson, an associate clinical professor of psychiatry at both Wayne State University and the University of Michigan, is in private practice in Ann Arbor. Other officers include: **Richard A. Ruzumna, MD**, secretary, and **Marvin L. Starman, MD**, treasurer.

Richard T. Browne, MD, is the new vice-president of the OHEP Center for Medical Education. New directors include **Robert D. Allaben, MD**, and **Kenneth L. Bergsman, MD**. OHEP is a consortium of seven southeastern Michigan teaching hospitals. They include Mt. Carmel Mercy Hospital, Pontiac General Hospital, Providence Hospital, St. Joseph Mercy Hospital,

Oakwood Hospital, St. John Hospital, and William Beaumont Hospital.

Carl A. Gagliardi, MD, an MSMS past president, is the newly-appointed director of the Oakwood Hospital Women and Children's Center of Excellence. In this position, Doctor Gagliardi will organize and coordinate Oakwood's comprehensive regional medical services to women and children. Doctor Gagliardi most recently served as senior vice president and director of Oakwood's Medical Education and Continuing Education Department, a position he held for 10 years.

Alma Rose George, MD, is the new president-elect of the National Medical Association. She has served NMA as treasurer for the past six years and been an NMA member for more than 20 years. Doctor George served on the Michigan State Board of Licensure and Registration. She is a delegate to the Wayne County Medical Society and the Michigan State Medical Society. In addition, she has been president of the NMA affiliates, Detroit Medical Society and the statewide Wolverine Medical Society, which she now serves as secretary-treasurer.

Elizabeth E. Gresch, MD, is second vice president of the American College of Occupational Medicine. Doctor Gresch is senior occupational health physician for the Dow Chemical Company, Midland.

Jeffrey A. London, MD, is the new associate medical director for Children's Adolescent Services, Havenwyck Psychiatric Hospital, Auburn Hills.

J. Edson Pontes, MD, is chief, Section of Urology, at Harper-Grace Hospitals in The Detroit Medical Center. Doctor Pontes, also professor and chairman of the Department of Urology, Wayne State University School of Medicine, joins the medical staff from The Cleveland Clinic Foundation where he served as head of the Section of Urologic Oncology. Prior to joining The Cleveland Clinic, Doctor Pontes served as chief, Department of Urologic Oncology, Rosewell Park Memorial Institute, Buffalo, New York, where he gained international recognition for his research and treatment in urologic oncology.

Robert S. Rhodes, MD, is a new member of the board of directors, American College of Occupational Medicine. Doctor Rhodes currently serves as regional medical director for the General Motors Corporation, Western Detroit Personnel Division.

Wilmer M. Rutt, MD, FACPE, director, Center for Clinical Effectiveness, Henry Ford Health System, was a featured speaker at the American College of Physician Executives 1990 National Conference held recently in San Antonio, Texas. Approximately 700 physician executives attended sessions presented by Doctor Rutt and other health care leaders on bioethics, health care quality, physician evaluation, effective peer review, health care management, establishing medical standards, and more during the four-day educational event.

Joel R. Saper, MD, FACP, is the newly-elected president of the American Association for the Study of Headache (AASH), the nation's only professional medical society of specialists in head and face pain disorders. Doctor Saper is founder and director of the Michigan Head-Pain & Neurological Institute (MHNI) located in Ann Arbor. He established the Institute in 1978 upon leaving the

University of Michigan where he was an assistant professor of neurology. Doctor Saper is a board-certified neurologist and is currently clinical professor of medicine (neurology) at Michigan State University.

The Michigan Chapter of the American College of Surgeons recently elected new officers. They are: **Angelos A. Kambouris, MD**, Henry Ford Hospital, president; **John Ingold, MD**, William Beaumont Hospital, president-elect; **Anna M. Ledgerwood, MD**, Wayne State University, secretary, and **Lee R. Britton, MD**, Alpena General Hospital, treasurer.

Sidney L. Stone, MD, is president of the Wayne State University School of Medicine Alumni Association. He has served as class agent for the class of 1951 for over 15 years. Doctor Stone was elected to the Board of Governors of the Medical Alumni Association in 1986 and was chosen as president-elect in 1989. He will serve as president and chairman of the Alumni Association Board of Governors for a one-year term.

David Moses, MD, has joined the Oakwood Hospital medical staff in the Department of Maternal and Fetal Medicine. Located in the Oakwood Medical Office Building, Doctor Moses joins Federico Mariona, MD, and Randall Kelly, MD, in the practice, teaching and research of maternal-fetal medicine. Patients include pregnant women who have diabetes, high blood pressure, heart disease, who are over 35 years of age, or who are expected to have less than optimal outcome. Prior to joining Oakwood, Doctor Moses completed a fellowship in maternal-fetal medicine at Children's Hospital of Buffalo, NY. He completed his residency in obstetrics and gynecology at Hurley Medical Center, Flint.

Continued from page 10

the First of Michigan Corporation, has been elected the first chairman of the Bon Secours Foundation. Robert L. Hannon, Jr., has been named Gifts Committee chairman and Ralph J. Kliber, Program Committee chairman.

Other foundation officers include: Sister Anne Marie Mack, CBS, president; M. Jan Kay, secretary; Stephen J. Rallison, executive vice president; and Gary A. Jankowski, treasurer. The foundation board of directors also includes Mrs. John A. Boll; Mrs. Betty Brady; Edmund M. Brady, Jr.; Monsignor Francis X. Canfield; Mrs. Hans Gehrke, Jr.; Mrs. Fred W. Hooper; Mrs. Leo A. Marx; Mrs. Philip Meathe; John R. Schneider, MD; Donald N. Sweeny III; Steve Tsangalias, MD; and Mrs. Calier Worrell.

Transplant Specialty Center receives UNOS approval

The Transplant Specialty Center at St. John Hospital and Medical Center has received official approval from the federally-mandated organization, United Network for Organ Sharing (UNOS), to perform kidney and pancreas transplants. The Transplant Specialty Center will focus on patients with end-stage kidney disease and insulin-dependant diabetes.

Heading the transplant program is Henry K. Oh, MD, FACS, who came to St. John from Henry Ford Hospital where he served as director of the Pancreas Transplant Program and acting head, Division of Transplant Surgery. Doctor Oh received his medical degree from Yon Sei University Medical College, Seoul, Korea, and served his residency in general surgery at Henry Ford Hospital. He has been a transplant surgeon for 14 years and is certified by the American Board of Surgery.

Doctor Oh is the president-elect for the Transplant Society of Michigan and a board member of the Organ Procurement Agency of Michigan (OPAM).

The medical director of the new transplant program is Robert Provenzano, MD, a transplant nephrologist who was also trained at Henry Ford Hospital.

International symposium on fetus as patient to be held for first time in Michigan

Wayne State University/Hutzel Hospital is hosting the sixth symposium of The International Society of "The Fetus As A Patient." This international meeting, to be held October 25-27 in Detroit, is the first representation of this group in the Americas. Previous meetings have been in Yugoslavia, Israel, Japan, Italy and France. A broad range of investigations in perinatal medicine will be presented. The emphasis will be on key issues in the reduction of perinatal morbidity and mortality, as well as new technologies which promise improvements in future care. Physicians, nurses, nurse midwives and scientists are encouraged to attend this symposium.

Advances in ultrasound imaging and diagnosis, including invasive ultrasound, will be presented in a workshop format on October 24, the day preceding the official opening ceremonies. The formal meeting will be opened by David Adamany, president of Wayne State University. New ideas and trends in prenatal diagnosis, color doppler, genetics, and doppler flow ultrasound will be the featured topics the first day; fetal and maternal physiologic monitoring, innovative techniques, fetal

Continued on page 12

Continued from page 10

malformations and IUGR, the second day; and transvaginal sonography the closing day. Abstracts submitted for competition will be presented by scientists from around the globe during the Friday morning session. Presentations have been selected for their practical significance in modern and future perinatal care.

Accreditation (CME) is provided through WSU with seven hours in Category I for the ultrasound workshop and 20 hours for the symposium. The program also has been approved for 21 cognates, formal learning, by the American College of Obstetricians and Gynecologists. Registration for the ultrasound workshop (October 24) is \$150. Cost of the October 25-27 symposium is \$250. Combined cost is \$350. For further information, call: Ivan E. Zador, PhD, 313/745-7322.

Patients needed for study

Harper Hospital/WSU

The diabetes research team at Harper Hospital-Wayne State University (WSU) is conducting a comprehensive study that could benefit millions of diabetics. There are approximately 12 million Americans who have diabetes. Of those approximately half may not know that they have the disease.

Harper Hospital, which is the only center in the state participating in this study, is conducting research on a medication that may prevent diabetes from occurring in borderline cases. If the study proves successful it could benefit millions of predisposed diabetics.

A borderline case of diabetes mellitus occurs in individuals with an abnormal result to a glucose tolerance test. George Grunberger, MD, director of the diabetes program at Harper Hospital and principal investigator of the study, explains that persons with impaired glucose

tolerance do not have diabetes but may go on to develop the disease. Such individuals have a one in three chance of developing diabetes and close to a 100 percent chance of developing diabetes if a brother or sister is afflicted with the disease.

Participants in the study must meet the following requirements:

- Have a blood relative who has the adult onset of diabetes.
- Be between the ages of 30 and 60 years and not have diabetes.
- Individuals must not have any serious mental or physical diseases.

- Female participants must be willing to delay pregnancy during the three-year study.

Participants will receive a free complete medical history and a thorough physical examination as well as blood and urine tests. Nutritional counseling will also be provided. For further information on the study please call Tania McClendon, trial coordinator at Harper Hospital/ WSU, at (313) 745-1398.

Sinai Hospital

Sinai Hospital's Clinical Neuroscience Program is currently conducting medication research trials for persons with Alzheimer's and Parkinson's Disease.

Those qualified to participate in the study include anyone experiencing memory loss, confusion or other types of mental impairment that may be associated with Alzheimer's Disease, or shaking or tremors linked to Parkinson's.

For more information, contact Peter A. LeWitt, MD, director of the clinical neuroscience program, at (313) 493-5343.

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THE RACE IS ON

A look at Michigan's gubernatorial candidates

James J. Blanchard has served as the governor of Michigan since January 1983. Although he hopes to continue in his leadership role, come this November, his eight-year term as governor could come to a close. Senate Majority Leader John Engler is more than anxious to take over as Michigan's 46th governor. Should Governor Blanchard be reelected, what will be his priorities in terms of health care delivery? What will he do to help contain the cost of health care? What about health care for the uninsured? And finally, what will he do to address the professional liability crisis in Michigan? If Senator Engler is elected, what positions will he take on these issues? *Michigan Medicine* asked each of the candidates to write on these topics, to give MSMS members an informed choice at the polls. Governor Blanchard chose to provide a general statement of principles, while Senator Engler chose to elaborate on each of the questions asked. Each reply is revealing. We hope you will find them interesting. 🐾

High and rapidly escalating health care costs are a critical state and national problem that we must address. The United States spends more on health care than other developed countries. For example, Japan spends 6.7 percent of its GNP on health care, Canada spends 8.6 percent, and West Germany pays only 8.2 percent. Our health care costs have been rising at twice the rate of inflation, now consuming 11.5 percent of our GNP. They are estimated to rise to 15 percent by the year 2000.

Increasing health care costs cause concern among many groups. Rising costs threaten our citizens' ability to obtain adequate health care. In Michigan, one million people are uninsured. Nationally, the estimates run as high as 37 million. The majority of those fortunate enough to be covered by insurance receive their coverage through their place of employment. The ability of our businesses to compete effectively in national and international markets is threatened by health care costs. Finally, the demands that rising health care costs place on government — both as an employer and as the financier for Medicaid and General Assistance medical programs — threaten our ability to properly fund a broad array of human services.

There are several complex factors that contribute to the problems of escalating costs. Our aging population will continue to require more health services. The AIDS epidemic requires extensive health care resources. The costs of acute and chronic illnesses resulting from tobacco, alcohol, and substance abuse mount. Professional liability contributes to excessive costs as defensive medicine is practiced, and sophisticated, expensive techniques continue to proliferate.

The list could go on and on. There is no single culpable party or factor. We are all responsible and we all must share the responsibility for solving the problem.

My Health Care Cost Management Team assembled experts from every affected sector across the state to formulate strategies for managing health care costs. We are reviewing their findings and will make our recommendations for implementation.

There are numerous priorities in health care delivery in Michigan. Certainly one of the most pressing is to find ways to assure that all of our citizens have access to

necessary, quality health care services.

I believe that in order to expand access while controlling costs, we must significantly reform the delivery of health care. However, I believe that this is an issue which is best managed at the national level. I have been working with interested parties, including health care providers, to develop principles for reform at the national level.

I will continue to support health promotion and prevention activities in Michigan.

During the next four years, health care costs and health care access will be high priorities for all of us.

The Michigan Model for Comprehensive School Health Education now reaches nearly one million Michigan students with health education messages.

At the worksite, our wellness grant program reaches nearly 900 small- to medium-size businesses, serving approximately 180,000 workers, retirees and spouses. We will continue to reduce tobacco consumption in Michigan, especially among our youth, as the single most significant preventable cause of premature death and disability.

I will continue to support programs promoting maternal and child health. The expansion of Medicaid coverage to pregnant women above the poverty line, the institution of prenatal care as a basic health service and the creation of the maternal support services, including paraprofessional outreach of teams working with high-risk pregnant women in their homes, are indicative of the advances made in this area during my administration.

In the United States we have the most expensive and technologically advanced health care system in the world. Yet we remain the only developed nation with millions of citizens uninsured and with insufficient access to health care.

It is estimated that as many as 37 million Americans — or approximately 16 percent of all people below age 65 — are without health insurance. In Michigan, we know that about one out of every 10 per-

sons has no insurance.

My Task Force on Access to Health Care recently completed its work and submitted a report containing seven major recommendations. I am pleased that progress has been made or is underway on several of these recommendations. I will continue to push for funding and support for Healthy Start, an important package of basic coverage for young children without insurance.

I agree with the Task Force's conclusion that reform is most efficiently and logically accomplished at the federal level. I am working with leaders in Michigan and with our congressional delegation to help pave the way for action. I believe reform must involve both the public and private sectors and will rely upon the ongoing involvement of individuals, businesses, providers, government and others.

As we push for reform at the national level, we will continue to experiment with programs designed to increase access, such as the Health Care Access project in Genesee and Marquette counties.

In the mid 1970's and 1980's, severe crises threatened the availability and affordability of medical liability insurance in Michigan. We coped with those crises. The two largest insurers for physicians recently cut rates for the first time in a decade. That success can be traced to the tort reforms of 1986.

As you know, this is an issue that involves a balance of legitimate protection of consumer interests and protection of professional care providers from excessive lawsuits. Robben Fleming, former president of the University of Michigan, is studying this issue. He is one of the nation's preeminent scholars and has longstanding experience with these types of issues. I will wait for his recommendations, but when we receive these proposals, we will ready a package of bills and other measures for action when the new legislature convenes.

There is more that we are doing. Doctor Fleming's proposals will be system-wide. Access to prenatal care needs special measures. The Department of Public Health is now developing specific proposals for obstetrics.

During the next four years, health care costs and health care access will be high priorities for all of us. I look forward to working with the Michigan State Medical Society to fashion the needed solutions.

John Engler's view

Health care cost containment

The federal Health Care Finance Administration reports that during the decade of the 1980s increases in health care costs outstripped the Consumer Price Index by a factor of two. However, only one tenth of this medical inflation was due specifically to a rise in medical prices. The rest was due to population growth (one fifth), economy-wide price inflation (one third), and changes in the intensity of per capita use of medical services (one third). Rising income levels, an aging population, the increased incidence of illegal drug use, AIDS, sky-high medical liability costs and mandated benefits all contribute to health care cost increases.

Benefit managers, including state government, are increasingly turning to mechanisms like prior authorization, peer review and price controls such as DRG and RBRVS on reimbursement to keep costs down and to pressure physicians to provide the minimum number of procedures deemed necessary to treat a given patient. Many of these "cost containment" measures have been successful at reducing costs. However, I am concerned that judgments concerning "medical necessity" are more and more being taken out of the hands of physicians and put into the hands of insurance companies and bureaucrats, at great risk to patients and the quality of medical care. I believe that judgments on medical necessity must remain in the hands of medical professionals, and that state government and insurance companies should stay out of the practice of medicine.

In my opinion, Rand Corporation studies indicating that 20-30 percent of medical procedures are unnecessary for adequate patient treatment demonstrate the need to bring medical liability costs under control to remove incentives to practice "defensive medicine." Michigan has the highest medical liability costs in the nation, and sadly, this element of the cost containment equation has received too little attention by the present administration. One of my goals as Governor will be to get Michigan's liability costs in line with the rest of the nation.

Finally, a recent study by the Mackinac Center also indicates that state-mandated

benefits put the price of health insurance out of the reach of many citizens. The study noted that up to 25 percent of Michigan's uninsured could purchase health insurance if they had the option to buy a "no mandates" policy. As Governor, I will oppose new mandated benefits and encourage the offering of affordable new insurance products free of mandates.

Priorities in health care delivery

In my judgement, the most important role of state government is in the provision of public health services for prevention and health promotion. In fact, one of

I believe that much can be done to stimulate the development of affordable health insurance products for uninsured citizens.

my most recent accomplishments in the field of health policy was to facilitate an agreement on establishing and funding the Michigan Health Initiative, a nationally-recognized model program for prevention and health promotion programming that emphasizes work site wellness, AIDS prevention, health education and risk reduction. As Governor, I will endeavor to achieve the commitment made by the state in 1978 to fund a set of basic public health services on a 50-50 state-local cost-sharing basis. The recent recommendations of the Established Committee on Public Health provide an excellent starting point for defining this basic set of cost-shared services. Finally, infant mortality reduction will be a primary objective for public health programming in my administration.

Michigan's hospital system is undergoing transition as advances in medical technology are resulting in a greater emphasis on outpatient services and a need to develop new uses for inpatient capacity. Outdated licensing and certificate of need regulations hindering this transition must be revised or eliminated. For this reason, I support legislation to permit "bed banking" and the designation of primary care

hospitals to encourage the horizontal diversification of our hospital system and to provide a broader continuum of care. I also support the repeal of Michigan's certificate of need regulations because I believe that medical technology not only advances the quality of care, but that it will eventually help us turn the corner on health care costs.

Recent advances like lithotripsy, NMR scanning and a host of new outpatient surgeries have actually reduced costs by limiting or eliminating lengthy and costly hospital stays. The system of licensing for physicians also must be strengthened by dedicating physician licensing fees to support improved staffing for the Board of Medicine. Physician fees should be used to support licensing enforcement for physicians.

It also will be a priority of my administration to pay for the benefits we promise to reimburse in our state Medicaid system. Hospitals and nursing homes shouldn't have to sue the state in federal court to receive adequate reimbursement for services.

Cost savings from administrative reforms like the privatization of Medicaid, reduced regulatory costs, reduced liability costs and re-ordered state spending priorities can all be directed to meet this basic state obligation.

Liability reform

Under my leadership, Michigan came within three votes in the House of Representatives of achieving truly substantive medical liability reform. However, the intervention of the Michigan Trial Lawyers Association and the lack of leadership from the Governor seriously weakened these reforms. I nevertheless continue to support limitations on damages, a shortened statute of limitations, abolition of joint and several liability and other such reforms to bring liability costs under control. Factfinders and studies only defer leadership and decisionmaking, especially when their recommendations are ignored.

As Governor, I will vigorously pursue policies to bring Michigan's liability costs in line with the national average. If Michigan hospitals only paid the national average per bed liability cost, \$150 million could be saved or utilized elsewhere in

Continued on page 19

Michigan



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Continued from page 17

our health care system. Similar savings could also be achieved for physicians.

A hostile liability climate and inadequate Medicaid reimbursement are the two major reasons why nearly two-thirds of resident physicians in training plan to practice elsewhere, why less than 50 percent of Michigan physicians now participate in Medicaid and why Michigan has lost 10 percent of its obstetrical care capacity in the past eight years. It is no wonder that many pregnant women receive their first prenatal care when they show up in the emergency room for labor. If Michigan is going to keep its best and brightest medical minds and get a handle on reducing our atrocious infant mortality rate, then liability costs must be brought under control and adequate Medicaid reimbursement must be assured. As Governor, I will fight to accomplish these objectives.

Health care for the uninsured

Three-quarters of Michigan's million-plus citizens who lack health care insurance are either employed or dependents

of persons who are employed. I believe that much can be done to stimulate the development of affordable health insurance products for uninsured citizens.

To begin with, the state could permit the offering of "no-frills" policies free of state mandated benefits. According to the study I mentioned earlier, this change alone would make health insurance affor-

*...infant mortality
reduction will be a
primary objective for
public health
programming in my
administration.*

dable for 25 percent of individuals, farmers, and sole-proprietors by allowing them to purchase health insurance with pre-tax dollars through tax deduction incentives.

Secondly, I support many of the House Republican Task Force recommendations

to permit parents and grandparents to add children and grandchildren as dependents to their policies, and to provide tax credits for philanthropic purchases of health benefits for children.

Next, I would seek to establish mechanisms for groups of small employers to pool their purchasing power and obtain the discounts that are available to group purchasers of health care benefits for their employees. Providing the opportunity for low-income persons to "buy into" Medicaid also is an option that I would pursue to the extent that federal waivers could be obtained.

Finally, two immediate measures that state government can take to make health care coverage more affordable to uninsured citizens is to bring the cost of health care down by controlling liability costs, and by honestly paying the state's fair share of costs for Medicaid. When the state underpays for Medicaid, costs not reimbursed are shifted to private health insurance thereby making private health insurance less affordable to group and individual purchasers. ■

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ATTORNEY/PHYSICIAN

guidelines for inter-professional conduct

By Richard D. Weber, MSMS legal counsel

It has come to our attention that many attorneys are causing record copy companies to subpoena medical records without attaching an authorization or consent signed by the patient. This is unacceptable. Physicians should never honor a third-party request or subpoena for records without a properly executed authorization signed by the patient. The power of a subpoena should never be used to put a physician in the position of violating patient confidentiality through lack of understanding or intimidation. The attorney should be responsible to see that a proper authorization is submitted with the records request or subpoena. A physician who receives a records request or subpoena without such an authorization should immediately communicate refusal to comply and the reason to the initiating attorney.

The medical and legal professions have established an attorney/physician code covering this and related issues. The code is set forth verbatim.

Preamble

The provisions of this Code are intended as guides for physicians and attorneys in their inter-related practice in the areas covered by its provisions. They are not laws, but suggested rules of conduct for members of the two professions, subject to the principles of medical and legal ethics and the rule of law prescribed for their individual conduct.

This code recognizes that, with the growing inter-relationship of medicine and law, it is inevitable that physicians and attorneys will be drawn into steadily increasing association.

The professions of law and medicine owe a mutual cooperative duty to the

courts and to the American people. That duty and obligation is better executed when each profession has and exercises respectful understanding and cooperation. Justice is, and must always be, our mutual goal unhampered by inconvenience, laziness, incompetence or self-service at the expense of the public.

For the medical and legal professions to perform the full duties owed to society by each, it is required that the member of each profession extend toward the other full courtesies and amenities and engage in a mutual understanding of the problems of each other.

Requests for patient information

Reports and conferences: Reports on

the medical condition of patients shall be supplied by the physician upon receipt of a properly signed authorization, in as complete detail and as promptly as possible. The attorney shall give the physician reasonable notice and clearly specify points in which he or she is particularly interested.

Attorneys requesting medical reports and conferences with physicians shall be personally responsible for payment of reasonable fees for these services, including preparation time. Upon request of the physician, these fees may be paid in advance. Physicians' fees for treating the patient are on the basis of the physician-patient relationship, and the attorney is not responsible for payment of these services.

Further, an outstanding balance owed by the patient to the physician is not a basis to decline providing information to the attorney.

An attorney in disbursing money, either after settlement or after a judgement has been obtained, has an obligation to encourage payment of the physician's bill and to use every legitimate means to assure that the medical care charges of the attending physician are paid by the client.

Written requests for records: Records may be obtained by one of the following methods: (1) A request accompanied by a properly signed authorization of records only for the patient named; (2) A subpoena for records, properly executed and properly served (that is, signed by the county clerk and personally served with a fee); (3) Court order for production. Further, a request from a third party, such as a copy service, must be accompanied by a properly executed authorization, signed by the patient, or the records must not be disclosed to the requesting party. A photostatic copy of an authorization may be accepted in lieu of an original, where the authorization so provides.

If a physician is properly served with a subpoena for patient records, the physician should comply and produce the re-

cords on the date set forth in the subpoena.

Personally served court orders to produce records are different from subpoenas in that they are specific directives signed by a judge. A record request including a court order that a physician shall produce records regarding a particular patient should be considered and treated in the same manner as if the request included a properly signed authorization from the patient. A physician should then comply with the court order and produce the documents set forth in the order.

Those physicians involved with a federally-funded drug abuse or alcohol program may need a specific authorization form, and should contact the requesting attorney or, if known, the attorney for the patient.

A properly executed authorization is only valid for the patient named. If there is any co-mingling of other patients' records contained therein (that is, another family member), contact the attorney requesting the records.

If all else fails, if the physician has a question about the legality of the subpoena, order, or authorization, he should contact the requesting attorney or, if known, the attorney for the patient.

Attorney-physician conferences

It is recommended that physicians meet with attorneys for pre-trial and/or pre-deposition consultation. These conferences may be days, weeks or immediately prior to the physician's testimony. Physicians have the right to be paid reasonable compensation for the time spent in preparing for and giving of the conference. This fee may be agreed upon in advance. When a physician is a treating or examining physician, he or she may talk to the patient's attorney or the opposing attorney with proper authorization. It is not improper to talk to the opposite side's attorney in a conference. Attorneys have an ethical obligation not to ask physicians for a conference without proper written authorization, if this is against the law.

Subpoena for testimony

The attorney should determine whether or not the physician should be served with a subpoena. If the physician is to be served with a subpoena, the attorney should advise the physician of the reason for serving one (for example, because the service of a subpoena is necessary to lay the foundation for a continuance, should the physician be unable to attend the trial due to an emergency or other cause). If service of a subpoena is deemed necessary, the attorney should advise the physician in advance and, if possible, arrange for the service of the subpoena at a time and place satisfactory to the physician.

Depositions

Obligation to provide: Court rules provide that trials shall not be adjourned for unavailability of an expert witness. Therefore, it is imperative for counsel to have a transcript of a physician's deposition testimony available for reading. Courts will enforce the taking of a deposition; however, since the physician is not a party to the lawsuit, it may be necessary to subpoena the physician. Unless the physician has a compelling reason to resist the granting of a deposition, it should be consented to, without requiring a subpoena. If, however, the physician does have a compelling reason to resist, the physician should then contact the requesting attorney immediately.

Date, time and place: It is essential that the attorney requesting the deposition provide sufficient advance notice to the physician, so that proper scheduling of date, time and place can be arranged. Court rules provide that depositions may

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Continued from previous page

be taken at any convenient date, time and place. The usual and customary practice is for depositions to be scheduled to suit the physician's availability and at the physician's office or other convenient place. Therefore, if for some reason a deposition is not scheduled conveniently at a suitable place, contact the requesting attorney for alternative arrangements.

Manner of taking deposition: Technical requirements should not concern the physician, but he or she may be guided by the requesting attorney. If the deposition is to be taken by videotape, proper arrangements for the physical aspects should be made in advance. The physician may request that he or she be allowed to read and sign the transcribed deposition. Ordinarily, however, the physician may waive the signature, unless there is a particular reason for concern about the accuracy of the transcription.

Fees: Fee shall be fair and reasonable and shall be consistent with the time involved and the cost incurred, based on the physician's hourly rate. The time involved may include the necessity for review prior to the deposition, whether with or without the presence of the requesting

attorney. Costs directly incurred (for example, the deposition may have been scheduled and cancelled on several occasions or the physician may be requested to photostat records) may be included. To facilitate payment, an itemized statement is suggested. Responsibility for the payment of a fee rests with the requesting attorney. Expert witness fees must be set by the court according to statute. Ultimately, the court can be called upon to determine the fee.

Duty to testify

Our system of justice depends upon the court's ability to require any citizen's attendance at a judicial proceeding and giving testimony regarding the case. There is no question as to the obligation of the physician to respond to a subpoena, just as any other citizen, except when an emergency prevents the physician from doing so. An emergency can never be a mere matter of convenience to the physician. The physician assumes the risk of convincing the court that the emergency was of sufficient gravity to justify ignoring the order of the court. Under these circumstances, the court or the requesting attorney should be advised immediately.

The attorney should use every effort to schedule the physician's testimony, so as to require a minimal disruption of the physician's normal schedule and should not require any physician to wait in court on call for an excessive length of time.

Consideration and disposition of complaints

All disputes or complaints by any member of either profession concerning a member of the other profession relative to alleged violations of the principles stated in this code shall be referred in writing to the chairman of the Medical-Legal Liaison Committee. If upon investigation this committee finds that the complaint has merit and is not resolvable, the committee shall then exercise its independent judgment and take an action as it deems appropriate. If the professional refuses to cooperate with the recommendations of this committee, that information shall be transmitted to the governing board of his or her own society or association for appropriate action, and the other professional organization shall be so advised.

Richard Weber is an attorney with Kerr, Russell and Weber, Detroit.

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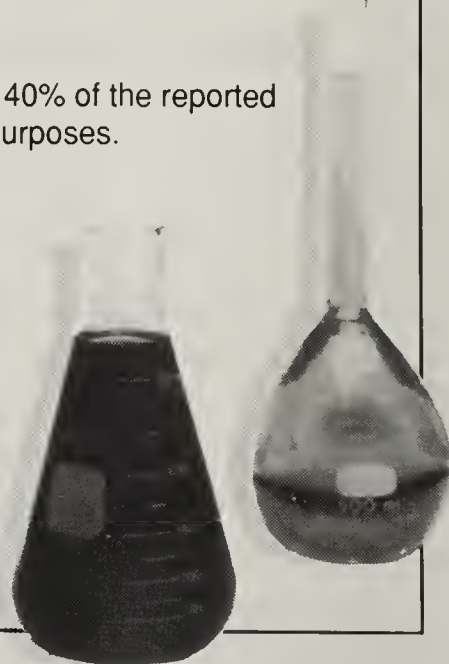
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Medical Inquirer



Data and Trends Affecting Michigan Physicians

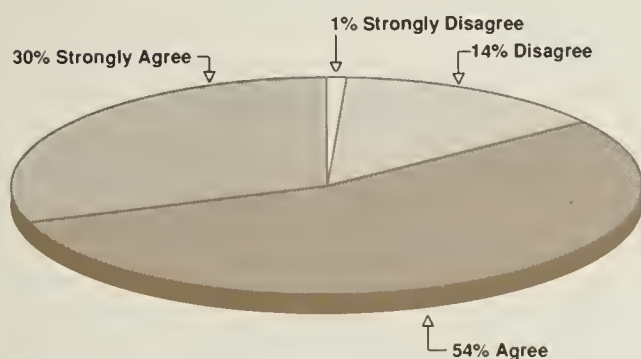
Issue 1

October, 1990

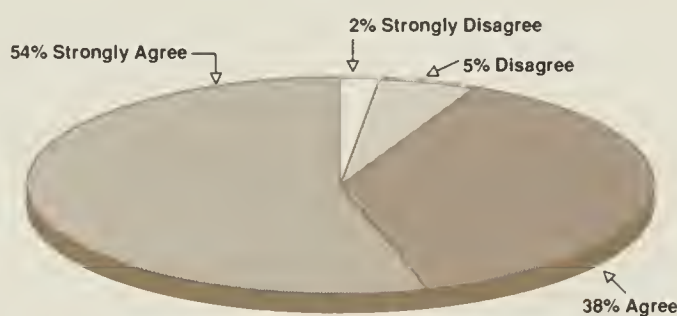
Employer Survey: Perception of Crisis is Spreading

Employers are increasingly worried about the problems of health care. In 1985, 84% of CEOs surveyed agreed that the U.S. is facing a health care crisis, but in 1990 that number increased to 92%. The study, conducted by William M. Mercer, Inc., surveyed chief executive officers of the 5,000 largest U.S. companies.

The United States is facing a health care crisis



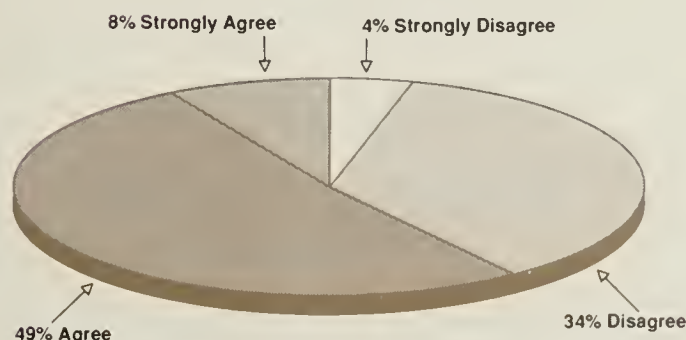
1985



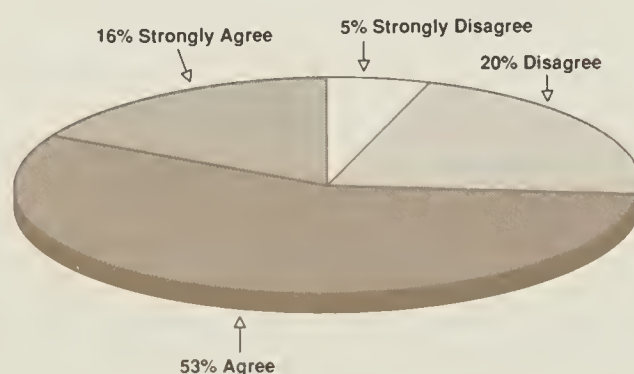
1990

An increasing number of CEOs believe this crisis is resulting in a two-tiered system of health care. In 1990, nearly seven out of ten agreed with this assessment, an increase of 12% since 1985. The perception of the cause of escalating medical care costs has changed over time as well. In 1985, employee insulation from costs was the most often cited reason - in 1990, it was the high cost of new technology.

High costs and limited access to high-tech care will create a two-tiered medical system - one for the rich and one for the poor



1985



1990

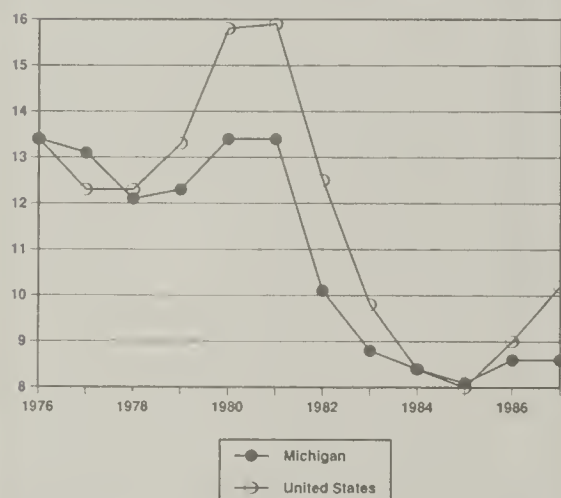
Source: William M. Mercer, Incorporated. "Employer Attitudes Toward the Cost of Health Care - 1990." New York, NY, 1990.

Increase in Michigan Health Expenditures Slower than U.S. Growth

The annual increase in personal health care expenditures in Michigan has slowed considerably since it peaked at 13.4% in 1980 and 1981. The growth in Michigan has consistently been below the United States as a whole since 1978, and while the U.S. rate began to rise again in 1986, the Michigan rate remained steady.

Personal Health Care Expenditures

Annual Percent Increase

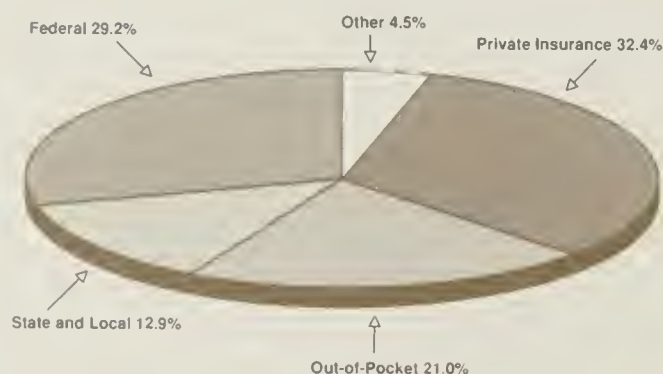


Personal Health Care Expenditures and Liability Premiums
Michigan 1977-1987
Annual Percent Change

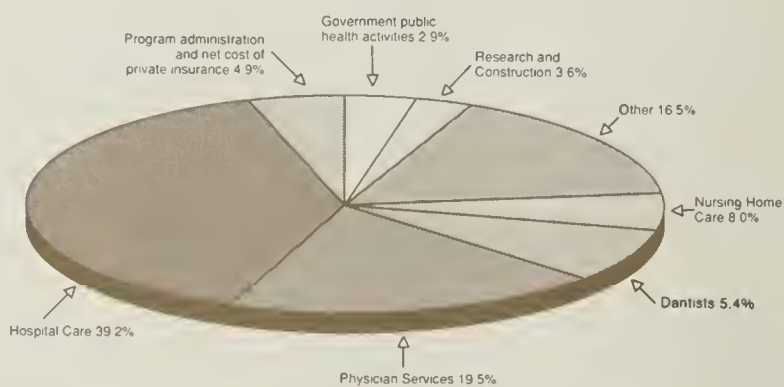
	Michigan	United States	Medical Liability Premiums*
1976	13.4	13.4	
1977	13.1	12.3	0.0
1978	12.1	12.3	-2.2
1979	12.3	13.3	-5.0
1980	13.4	15.8	0.0
1981	13.4	15.9	-9.7
1982	10.1	12.5	6.0
1983	8.8	9.8	5.4
1984	8.4	8.4	23.8
1985	8.1	8.0	58.4
1986	8.6	9.0	70.0
1987	8.6	10.2	15.0

* Liability premium data represent the experience of MPMLC only. It is not intended to represent premium changes of all medical liability insurers, but only to serve as an example.

At the national level, 58% of health care dollars in 1988 came from consumers, primarily through insurance and out-of-pocket payments. Physicians services accounted for 19.5% of health expenditures. All provider groups received nearly three-quarters of the health care dollars spent in 1988, with the remaining portion going for administration, research and other activities.



Sources of Health Care Dollars
1988



Where the Money Goes
1988

Source: Health Management Associates, *Michigan Health Economic Series 3* (August 1988): 7.
Health Care Financing Review 10 (Winter 1988): 113
Michigan Physicians Mutual Liability Company.
Health Care Financing Review 10 (Spring 1989): 4-6
Medical Benefits (July 15, 1990): 6.

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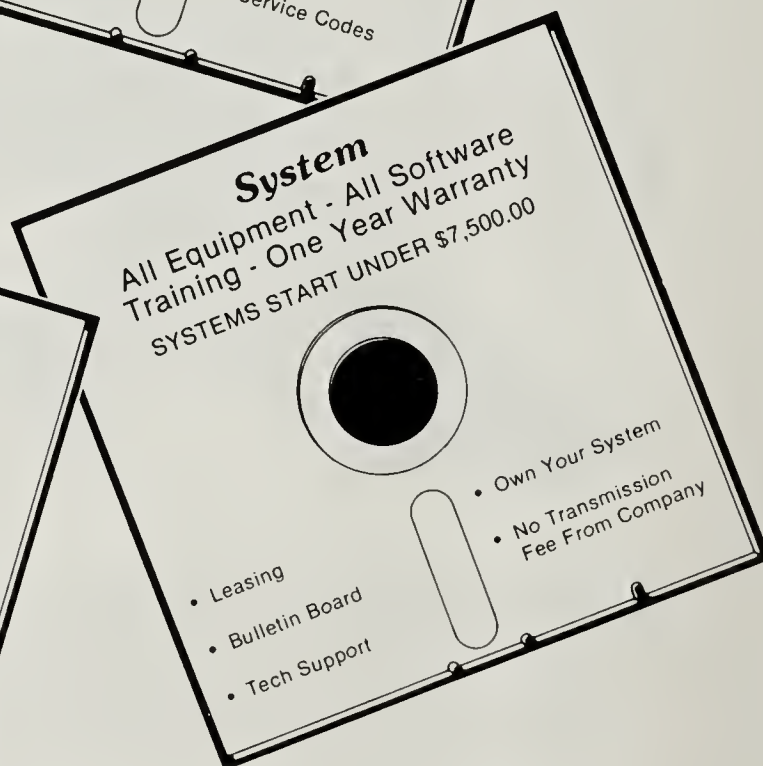
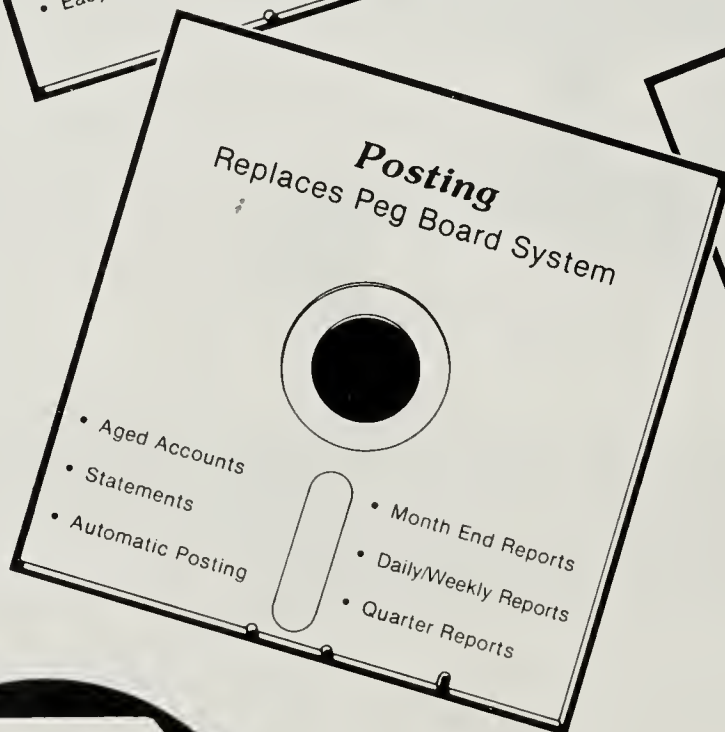
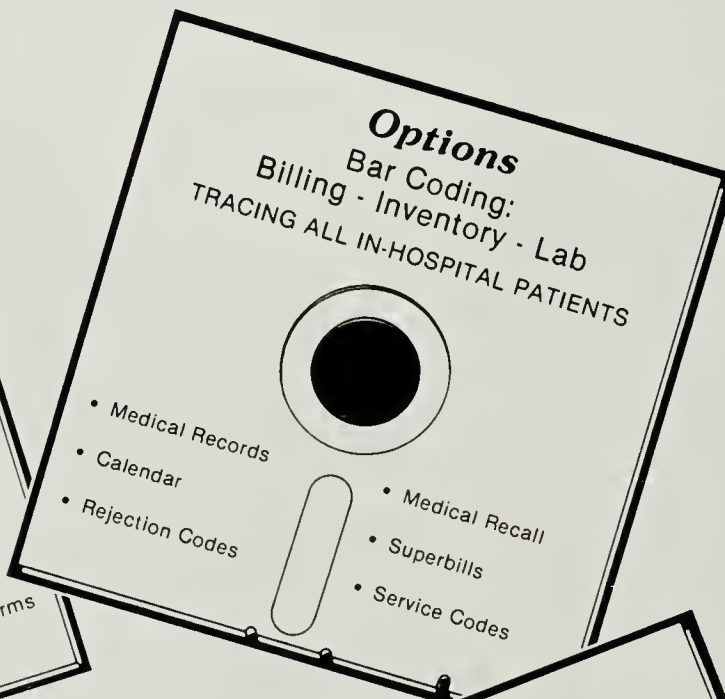
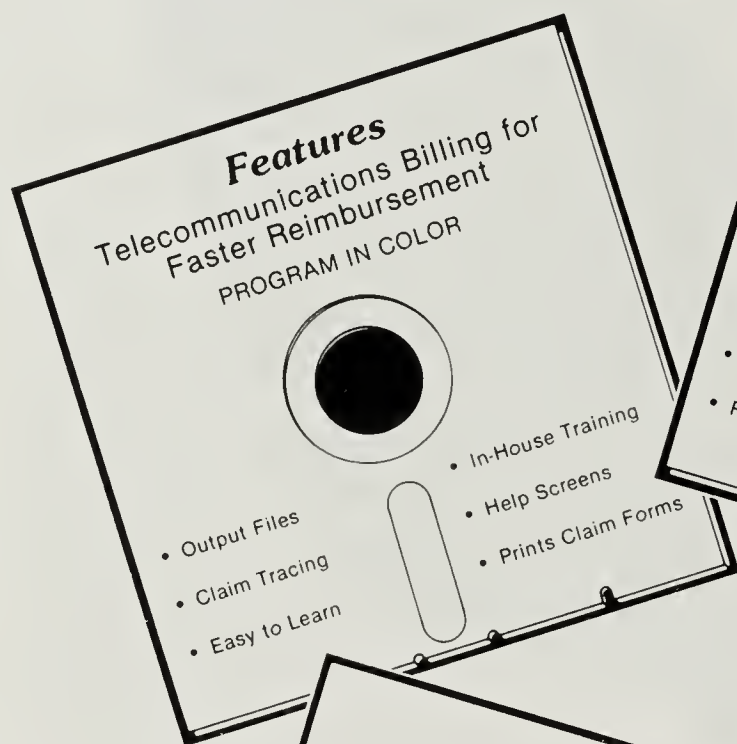
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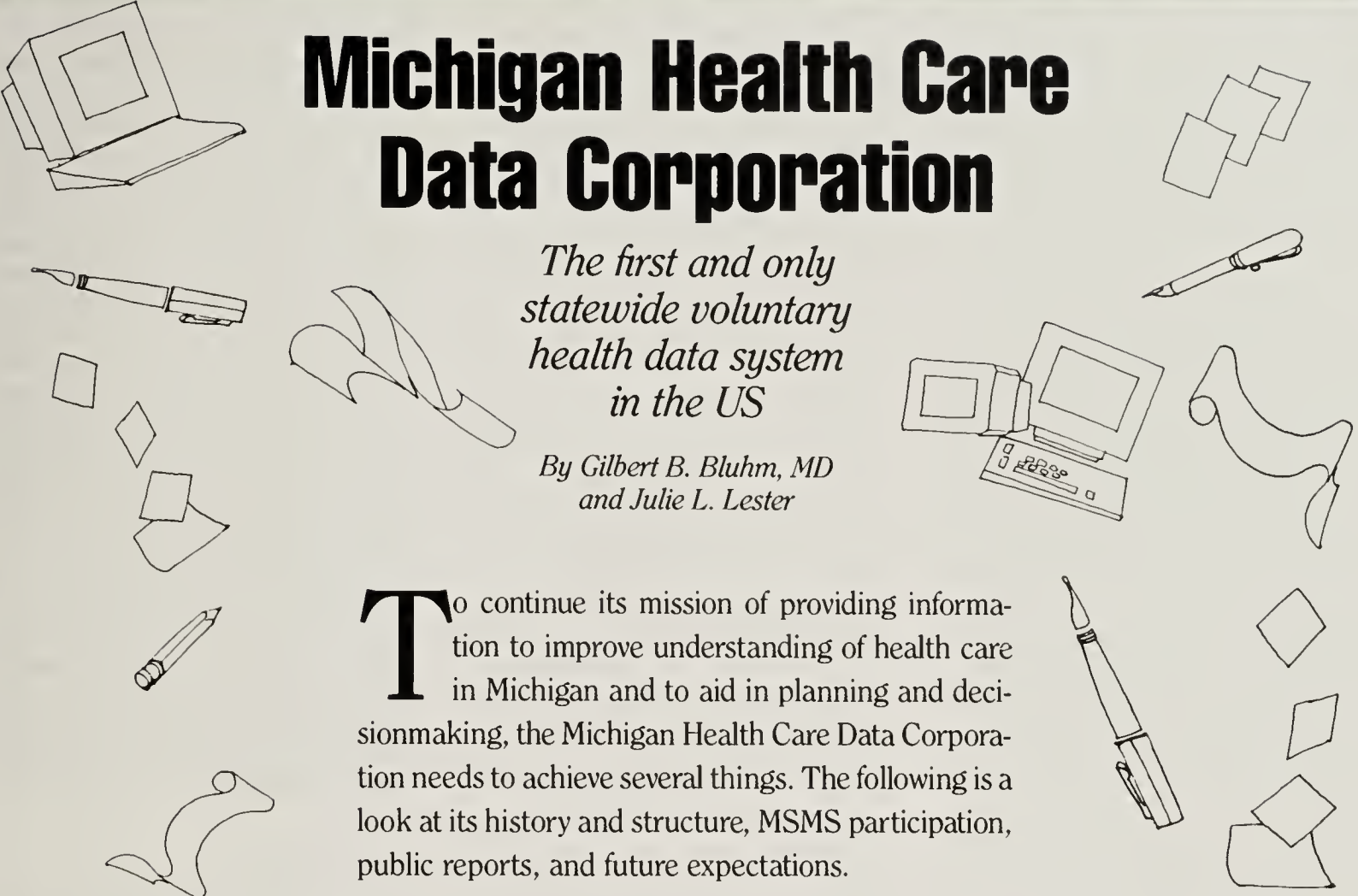


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*By Gilbert B. Bluhm, MD
and Julie L. Lester*

To continue its mission of providing information to improve understanding of health care in Michigan and to aid in planning and decisionmaking, the Michigan Health Care Data Corporation needs to achieve several things. The following is a look at its history and structure, MSMS participation, public reports, and future expectations.

History and structure

The Michigan Health Data Corporation (MHDC) originally started in 1978 as a voluntary non-profit organization whose purpose was to create the Michigan Inpatient Data Base (MIDB). Providers, state agencies, and universities cooperatively produced the data base to provide a central source of inpatient hospital data. Since the inception of the Prospective Payment System, demand for health care data has increased. The Office of Health and Medical Affairs convened a task force in 1986 to look into this need for health care data. The task force arrived at a recommendation for a statewide voluntary organization which would house data resources and produce routine public reports. This recommendation eventually led to the designation of the MHDC as the center for the voluntary health data system. Michigan's solution lies in contrast to mandatory systems that have developed in such states as in Pennsylvania, which are costly and adversarial.

In response to this new responsibility, the MHDC increased its membership to include purchasers, consumers and other groups and altered its governing struc-

ture. Membership in the organization is divided into three categories: (1) provider; (2) consumer/purchaser; and (3) other, which latter includes state government, universities, insurers and consultants. The officers in the MHDC must rotate through the three constituency groups. Officers are nominated by the constituency group which is responsible for the office in that year, and they serve a one year term. Previously, the president came from the provider category. The current president is George Van Amburg of the Michigan Department of Public Health, who represents the "other" constituency group. The 1991-92 president will be Janice Gross of the Office of Health and Medical Affairs, who represents the consumer/purchaser group. Jane Deane Clark, PhD, of the Michigan Hospital Association serves as executive director.

The MHDC has developed access and oversight guidelines by which all parties must abide in order to gain access to any data. All requests for data are reviewed and evaluated for compliance with the principles. The most important concern is protecting patient confidentiality. Any party contributing data to the MHDC can

write a contract with the corporation that specifies any limitations that would apply to that data.

At this time, the MHDC holds the MIDB and a merged claims data base comprised of Medicare, Medicaid and Blue Cross data. Aggregate tables from OHMA's physician census survey also have been donated to the MHDC's holdings for marketing and distribution in the near future.

Each member organization has a seat on the Board of Directors. The Executive Committee meets regularly to handle business between board meetings. MHDC has seven subcommittees which advise the Board on a variety of issues: Access and Oversight is responsible for reviewing requests for access to data and ensuring that the access principles are enforced. Finance establishes access fees and monitors the finances of the corporation. Products oversees development of products from the data bases MHDC holds. Community Affairs and Education is charged with creating a public image, developing seminars and packaging public reports.

Continued on next page

Nominating develops slates and handles membership issues. Constituency Support is responsible for helping members learn how to use the data and identifying information needs of the group and strategies for meeting those needs. The Technical Advisory Committee handles the technical issues involved with constructing the MIDB and the processing of other data bases.

The MHDC collects dues and venture capital contributions to fund the acquisition of the data bases and the development of data products. MHDC instituted a dues increase for 1990-91, since additional funds were needed to meet the expenses of the organization. The regular operating expenses include the computer time and personnel needed to create products and assemble the data bases. Other than these functions, all other work is handled on a voluntary basis by the officers and the executive director, as there is no paid staff. A long term goal of the organization is to generate a steady stream of revenue from products to stabilize its financial position and to allow it to hire regular staff. The addition of this revenue would supplement the dues members pay and would ease the administrative burden they now bear.

MSMS participation

MSMS has been a member of MHDC since it formed in 1978. After MHDC reorganized in the late 1980's as the center for the voluntary system, MSMS took an even more active role, participating in the Executive, Access & Oversight, and Products committees. MSMS chaired the Access & Oversight Committee during the development of the access and oversight guidelines.

The MSMS Board of Directors adopted the principle shown in Diagram A at its October 1989 meeting as the criterion for continued participation by MSMS in MHDC. The cells under public access represent the broadest types of reports, and any future negotiated access would be

based on experience with these reports. The MSMS Board decided that the activities in Cell 1, Current, under public access must be completed before taking the next step to negotiated access. Then, the activities in Cell 2, Near Term, would be handled in the same way, and finally those in Cell 3, Ideal. This would allow MSMS to evaluate the the reports, the fairness of the process, and the commitment of other members. MSMS is committed to the idea that in order for a voluntary system to work, purchasers must be equally committed to sharing data on the health of their workforce and the workplace environment.

At the time of the dues increase, the MSMS Advisory Committee on the Section on Medical Economics, the MSMS Finance Committee, and MSMS Board of Directors reevaluated their previous positions and examined the developments in MHDC through a presentation developed by the MSMS Advisory Committee on the Section on Medical Economics, headed by Gilbert B. Bluhm, MD. The MSMS Board considered four options regarding future participation in MHDC:

Fully participate: Abide by the consensus decisions of the MHDC board.

Participate according to MSMS policy: Continue with the policy of requiring all cells in public access level to be completed before moving on to negotiated access. (See Diagram A.)

Opt out of the MHDC: Withdraw from the MHDC Board and committees and no longer participate in the discussions on voluntary data release.

Pursue a legislative resolution: Draft a bill to be introduced in the legislature which would establish a mandated data system.

Fully participating by agreeing with what the MHDC Board decides without actively lobbying to protect physician interests would not provide a strong leadership position. Given the political climate and the loss of control that a legislative solution represents, that option also did not appear to be a viable choice. Opting out of the MHDC would mean that physicians

would no longer have a seat at the table to monitor developments and to participate in decision making. The MSMS Board decided at the March 1990 meeting to continue the previous policy. This option had several advantages. MHDC has successfully reached its first goal of producing the public reports and it may be able to sustain its momentum and gain strength. This achievement also stands as proof that the providers have kept their promise to provide public reports. The initial resources that were committed to MHDC, both in dollars and in staff resources, made completion of the goal possible. The voluntary efforts within MHDC also have helped to forestall a complicated, expensive and burdensome mandated system which would be created without much input from the provider community. It also keeps the providers in a position of negotiating from strength and with influence on the process and the final outcomes. At this time, MSMS sees enough potential benefit to warrant further commitment. If any of the factors change and it is no longer in the interest of the members to participate, the decision can be made to withdraw from MHDC.

Public reports

With the release of the aggregate hospital reports, MHDC has reached the first of its goals for publication of health care data. This step affirms that the process of cooperative negotiation among the many different parties involved can lead to a productive outcome. These first reports tested the commitment of the MHDC members to establish rules that would be fair to all parties, to agree on measures to be used in the reports, to solve the technical problems in the development and production of such reports, and to provide the financial and staff resources required.

The public reports consist of eight volumes, one for each of the health service areas. Each report will contain regional data for the top 35 DRGs and 15 selected surgical procedures compiled from inpatient medical abstracts. Hospital-specific

Access & Data Contribution

	Cell 1 CURRENT	Cell 2 NEAR TERM	Cell 3 IDEAL
PUBLIC	• Currently Agreed Upon Public Reports	• Additional Hospital Specific Reports • Grouped Physician Data • Grouped Purchaser Data	• Highly Specific Hospital Data • Physician Specific Data • Purchaser Specific Data
NEGOTIATED	• Additional Hospital Specific Reports • Grouped Physician Data • Grouped Purchaser Data	• Highly Specific Hospital Data • Physician Specific Data • Purchaser Specific Data	• Patient Level Information

payment and utilization data also are reported for the top 30 DRGs and 15 surgical procedures from aggregated paid claims data from Medicare, Medicaid, and Blue Cross Blue Shield of Michigan.

Future expectations

At this time the third party payers do not have strong member representation in MHDC. The Economic Alliance of Michigan has not paid dues and therefore no longer has voting privileges. The United Auto Workers is still participating and it and the Department of Social Services Medical Services Administration (Medicaid) are members of the consumer/purchaser constituency. Blue Cross & Blue Shield of Michigan participates under the "other" category. The Health Insurance Association of America was participating, but since it has not paid dues, it no longer has voting privileges. Better participation and commitment of data by third party payers are necessary for the completion of aggregate purchaser reports.

To continue its mission of providing information to improve our understanding of health care in Michigan and to aid in planning and decisionmaking, MHDC

needs to achieve several things. It needs to generate sufficient revenue from products to stabilize the resources of the organization and to allow it to hire staff. It needs to expand its data holdings, with some combination of additional insurance data, physician acute care data, and ambulatory care data in health care facilities (as opposed to physician offices). Purchasers will eventually need to produce aggregate data for MHDC to publish. The MSMS Board feels that a true statewide health data system should include information on the causes of disease and injury in both environment and workplace, to allow policymakers and planners to address these problems in order to reduce unnecessary suffering and cost.

Obtaining the resources mentioned above will allow MHDC to expand its health care data holdings beyond acute care facilities, to get more of the total health care picture. Although pressure from consumers and purchasers may have created the need for a voluntary data system, it is the providers who may benefit the most from this process, due to the self-discovery that takes occurs when providers look at the data and gain a better

understanding of what it shows. For example, providers have never seen detailed aggregate ambulatory care data, which is the area of greatest growth in health care in the last decade. These data could be used to gain a better understanding of ambulatory services and to plan for future needs. The process that MHDC is going through will allow providers to use shared resources to produce this data, while allowing them to maintain control over how the data is displayed and disseminated.

The future activities of MHDC will place it on the cutting edge of policy development for the collection and use of health care data, since it is the first and only statewide voluntary health data system in the United States. MSMS will continue to be an active player and will seek the best solutions for its members in this challenging segment of the health care arena. ■

Doctor Bluhm is chairman of the MSMS Advisory Committee on the Section on Medical Economics. Julie Lester is chief of health care research, MSMS Department of Economics and Health Care Delivery.

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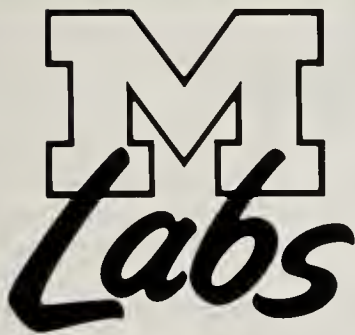
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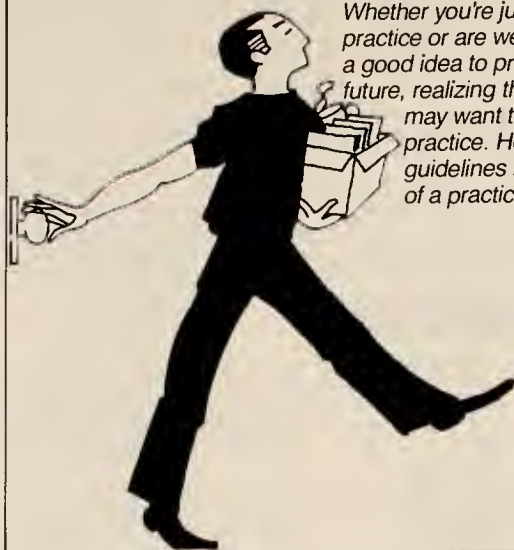
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Disposition of a Medical Practice

"One thing in life is certain, things change."



Whether you're just starting a practice or are well-established, it's a good idea to prepare for the future, realizing that someday you may want to sell or close your practice. Here are some guidelines for the disposition of a practice.

Closing the practice

If you're thinking of retiring and closing up your practice you need to plan well in advance of the targeted retirement date. Here are some important steps to take:

1. Inform patients. Notify each patient of the physician's termination of medical care in writing. Provide adequate time for the patient to arrange for alternate medical care. State the date you will be discontinuing medical practice. A reasonable time period can be determined based on the availability of alternate health care providers in the immediate geographic region. For maximum protection, date the letter and send certified mail, return receipt requested. Place a copy of the letter and signed receipt in the patient's file.

2. Evaluate the needs of each patient. Refer patients to other physicians and, with the patient's authorization, provide medical information to their new physicians. Those patients with critical health care needs, or unstable conditions requiring medical supervision, must be referred to a specific physician competent to handle the case. Verify and document that the patient has been accepted into this physician's practice. A signed authorization from the patient for release of medical records, with written notation that the records were released to the physician designated, would provide adequate

verification and documentation.

3. Inform colleagues. Notify your colleagues, as you may be referring some of your patients to them.

4. Notify all related business connections. This will include the office leaseholder, the hospital, colleagues, state medical licensing board, state medical society, Drug Enforcement Administration, post office, journals, magazines, and phone company.

5. Arrange for long-term record storage. Retaining medical records is necessary in case of future legal action. Records must be kept accessible and readable for a reasonable amount of time. (See patient records section.)

6. Obtain "tail" coverage. After terminating claims-made professional liability insurance, "tail" coverage can be arranged. This provides insurance in case a claim is asserted or a lawsuit is filed after you retire.

7. Sell equipment. Determine the value of the medical and office equipment, supplies, and medical records so a buyer can be sought. (See equipment section). Any monies derived will be considered income.

8. Group practice. If you are in a group, retirement provisions written into financial agreements can help prepare the group for the retirement of a partner.

An alternative

A medical practice does not have to end with a physician's retirement. A practice has its own inherent value, independent of the physician.

Patients don't like to leave a practice if they can avoid it. Their records are there, they know the staff, the surroundings are familiar. They're comfortable.

The key is to make a rapid transition from one physician to another, the sooner the better. Whatever the practice is worth before the physician retires or dies, is what it is worth after, provided the patients are still there. There are two alternatives:

1. Selling your practice. Potential buyers include hospitals, HMO's, other physicians interested in expanding their practices, and new physicians in the community.

2. An associate. Another option is to take in an associate who will buy into the practice. The retiring physician should not announce retirement plans until the new physician is established in the practice. Otherwise, patients may seek a new physician and the value of the practice could drop rapidly.

Thinking ahead

You should make a comprehensive list of what your spouse needs to know about

the practice. This list should be kept with your letter of last instruction or be discussed with your spouse. Here are some of the things your spouse will need to know.

- The physician's taxpayer ID number and Social Security number.
- Employees' names, addresses and phone numbers.
- Covering or referral physicians and how to contact them.
- Hospitals and nursing homes where the physician has patients.
- Business bank accounts.
- Location of accounts receivable; patient receipts; unbanked cash; uncompleted insurance forms; accounts payable; and unpaid bills.
- Past five years local state and federal tax returns.
- Narcotics appointment books.
- Office lease or deed.
- Prepare a will; inform your spouse of its location.
- Inform the personal representative regarding the disposition of your practice.
- Have your practice appraised. This should be updated every two to three years.
- Chart extensively. Assume the record will have to stand entirely on its own merit in court.
- Retain all originals.

When the physician dies

If you are the personal representative of the physician's estate, and you must close his/her practice, here are some guidelines:

1. **Contact colleagues.** Contact the covering or referral physicians to arrange for coverage of patients in the hospital or in nursing homes.

2. **Consider selling the practice.** If selling the practice, with or without real estate, rapid action is advised because the practice will lose value quickly. Contact a broker or advertise in medical society journals.

3. **Retain one or more employees temporarily.** It's a good idea to retain some office personnel to assist you. Outstanding bills and normal turnaround time for receipt of payments will influence how long they will be needed.

4. **Notify patients.** Have your office personnel contact patients who have upcoming appointments. Send a form letter to all active patients regarding the physician's death, referrals, and transfer of records. A return envelope and authorization form should be enclosed.

5. **Patient records.** Retaining the original medical record, including

The following letter can be used as a model for physicians who are discontinuing practice:

Dear Mr. _____

Please be advised that because of _____

(my retirement, reasons of health, etc.)

I am discontinuing the practice of medicine on ____ 19 _____. I shall not be able to attend you professionally after that date.

I suggest that you arrange to place yourself under the care of another physician. If you are not acquainted with another physician, I suggest that you contact my office, or Dr. _____, or the

_____ (local)

Medical Society.

I shall make my records of your case available to the physician you designate. Since the records of your cases are confidential, I shall require your written authorization to make them available to another physician. For this reason, I am including at the end of this letter an authorization form. Please complete the form and return it to me.

I am sorry that I cannot continue as your physician. I extend to you my best wishes for your future health and happiness.

Yours Very truly,

_____, M.D.

AUTHORIZATION TO TRANSFER RECORDS*

Date: _____

To: _____, M.D.

I hereby authorize you to transfer or make available to _____, M.D., _____, all the records and reports relating to my case.

Signed _____

*If a charge is to be made for reproducing the records, the following sentences may be added to the authorization to transfer records:

"I further understand that I will be responsible for the clerical and reproducing costs incurred in the copying and/or transfer of my records to the above named physician, should that physician request such records."

Continued from previous page

X-rays, is imperative to the defense of the physician's estate, in case of future legal action. Records must be kept accessible and in legible condition.

There is no law which stipulates the length of time a medical record must be retained. Because of the various statutes of limitations for professional liability, taxes and contracts, MSMS legal counsel recommends that records be retained for at least 19 years after the last treatment date for a minor (15 years regarding treatment after October 1, 1986), and at least seven years after the last treatment date for an adult. Because of certain tolling provisions of the statutes of limitations, however, the safest course would be to maintain them indefinitely.

In Michigan, patients have the right to access the information in their medical records, except in cases of treatment for mental illness. It is permissible to charge a fee for the legitimate costs incurred in assembling, copying and delivering the record. Costs are based on time spent (minimum if just copying records; office visit cost for a written summary).

6. Notify other people and organizations. Others who need to know about the physician's death include the state

medical society, specialty societies, the AMA, the landlord, utility companies, and the state board of medical examiners.

Michigan Department of Licensing and Regulation, Board of Medicine, P. O. Box 30018, Lansing, MI 48909, Phone: (517) 373-0680.

Michigan State Medical Society, 120 West Saginaw, P. O. Box 950, East Lansing, MI 48826-0950, Phone: (517) 337-1351

(Michigan State Medical Society has health insurance benefits available for surviving spouses.)

7. Insurance refunds. Contact the professional liability carrier. Arrange for "tail" professional liability coverage, which will insure the estate after the regular liability insurance has been terminated.

Remember to keep the business office insurance until all employees have left and the office is officially closed.

8. Equipment. Medical equipment is best disposed of as part of the practice. Otherwise have the value appraised by a reputable equipment vendor and try to sell it privately, through advertising in a medical journal, hospital bulletin boards or staff room, local paper, or to a dealer in used equipment.

9. Dispose of narcotics, medications

and drug samples. Destroy all prescription forms. Remove all physician signature stamps. Dispose of all office pharmaceutical samples. Destroy or return all controlled substances. If controlled substances are kept in the office notify the Federal Bureau of Narcotics by phone or mail. Controlled substances may be disposed of by returning them to the agency via registered mail, or by destroying the drugs in the presence of a witness and filing DEA form 41. Contact: Federal Bureau of Narcotics (DEA), 231 West Lafayette, Room 357, Federal Building, Detroit, Michigan 48226, Phone: (313) 226-7290.

Editor's note: The statements and recommendations herein are general guidelines and are not to be construed as constituting legal advice.

Sources: Michigan Medicine, "How to Handle Disposition of a Medical Practice," by Ruthmarie Shea-Atallah, RN, BS, MA, April 1987.

"What Every Physician's Spouse Should Know...Retirement and Estate Planning," American Medical Association Auxiliary, Inc., 1987.

For a sample patient notification form and authorization to transfer records, see page 35.

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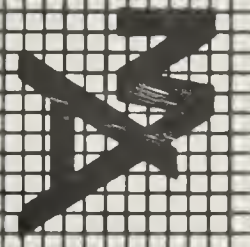
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Graduate Medical Education

and State Law

By Gerald H. Mandell, MD

In the past several years there has been a nationally growing concern that hospital house officers have been working to the point of exhaustion in their training programs. Such overwork causes severe house officer stress and may cause problems in medical judgment imparting negatively on patient care. The State of New York has passed legislation restricting house staff hours (with certain exceptions) to 80 hours per week. Legislators throughout the United States have entertained similar legislation.

This year, Senator John Kelly introduced SB 584, a bill that would restrict house officer hours of work by legislation and regulation. There appears to have been some early support for such legislation by house officers who shared Senator Kelly's concerns.

Meanwhile, the AMA, its Council on Medical Education and its conjoint ACGME Committee, were examining the issue from organized medicine's viewpoint. All residency programs seemed desirous of reaching an 80-hour per week maximum workload, but there were legitimate concerns that unduly restricting work hours would limit the educational experience house officers were required to cram into their training years. Most residencies had little difficulty meeting an 80-hour limitation. Some, however, were deemed difficult to manage. The latter included general surgery, some surgical subspecialties, obstetrics/gynecology and internal medicine. Questions raised included:

1. Do hours on call during which the resident may sleep, count toward the 80 hours?
2. How are residents who moonlight controlled in terms of limiting hours?
3. How do house officers who may no



Doctor Mandell

longer moonlight survive economically and pay their debts (many having already accumulated large financial obligations)?

4. How can training programs be revamped to provide for patient care while limiting hours of education?
5. Shall a resident be required to complete a long procedure that may well overlap into off-time service?
6. How may consecutive hours may be worked before fatigue sets in?
7. How shall emergency coverage be handled?
8. What cost will there be to hospitals to provide patient care formerly provided by house officers?
9. Who will pay for this cost?
10. What is appropriate payment to house officers who have their hours of work significantly reduced?

In addition to these local questions, a major one is: Will state legislation interfere with national accreditation standards so that some of our residency programs will not meet the requirements? Why should Michigan be out of step with the

rest of our country? What would happen to postgraduate training essentials and requirements if each state developed its own criteria without respect to other jurisdictions? Would we not have an impossible situation against which to apply standards? Is the state prepared to develop its own residency approval structure? Will the law require time cards to be punched; time records to be kept? Who will track such records? What penalties will be imposed for failure to comply? Who will be penalized – our hospitals, our administrators, our teaching coordinators, or the chief resident who makes out the schedule? Will there be graded penalties should there be a one-minute violation vs a one-hour violation?

I have been informed that Senator Kelly has agreed to postpone deliberation of his bill for the current session to see if organized medicine can perform according to his understanding of the complexities of residency training. I believe it would be prudent for Senator Kelly to not pursue further legislative attempts to control what properly is a national problem.

I believe that the questions raised provide reason enough that our physicians of MSMS, our house officers and our medical students should continue to oppose SB 584.

Doctor Mandell is vice president for medical affairs, Sinai Hospital, Detroit. He is also past speaker, MSMS House of Delegates.

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

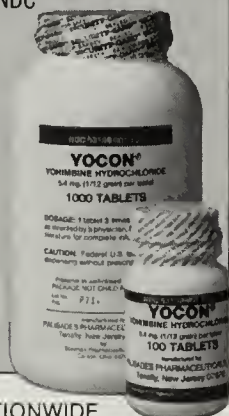
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Board of Medicine Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Robert L. Alexander, MD, Federal Prison Camp, Prisoner ID# 07841-039, 1201 Douglas Street, P. O. Box 700, Yankton, SD 57078

Action, Date Taken: Revoked, Fined \$50,000 prior to filing for reinstatement; August 3, 1990

Reason: Conviction – Drug Related

Name: Beverly L. Anderson, MD, 524 Byron Road, Howell, MI 48843

Action, Date Taken: Reprimand, Fined \$1,000, Probation two years, Earn 100 credit hours in addition to the 150 hours mandated for license renewal; September 3, 1990

Reason: CE Audit Violation

Name: Willard W. Capron, DO, 2106 Boston Blvd., Lansing, MI 48910

Action, Date Taken: Suspended June 8, 1989 to August 2, 1990, Limited License commencing; August 2, 1990

Reason: Negligence

Name: Donald A. Caraccio, MD, 2821 Sparta, Troy, MI 48083

Action, Date Taken: Suspended, three years; May 8, 1988

Reason: Conviction – Drug Related

Name: Richard Keith Clise, MD, 6127 Winthrop Court SE, Grand Rapids, MI 49505

Action, Date Taken: Probation two years, Fined \$1,500; July 18, 1990

Reason: Negligence

Name: Frank R. Gould, MD, 153 Lafayette SE, Grand Rapids, MI 49503

Action, Date Taken: Reprimand, Fined \$1,000, Probation two years, Earn 100 credit hours in addition to the 150 hours mandated for license renewal; September 16, 1990

Reason: CE Audit Violation

Name: Richard P. Granse, MD, 1533 Beckwithview NE #7, Grand Rapids, MI 49505

Action, Date Taken: Probation three

years, Fined \$1,500, Reprimand; August 17, 1990

Reason: Mental-Physical Incompetency

Name: W. F. Kutsche, MD, 5007 N. Cedar Lake Road, Oscoda, MI 48750

Action, Date Taken: Reprimand, Fined \$1,000, Probation two years, Earn 100 credit hours in addition to the 150 hours mandated for license renewal; September 16, 1990

Reason: CE Audit Violation

Name: Noor Mohammed, MD, 20331 Farmington Road, Suite 103, Livonia, MI 48152

Action, Date Taken: Reprimand, Fined \$1,000, Probation two years, Earn 100 credit hours in addition to the 150 hours mandated for license renewal; September 8, 1990

Reason: CE Audit Violation

Name: Seldon Robert Nelson, DO, 4386 N. Meridian Road, Williamston, MI 48895

Action, Date Taken: Limitation; August 2, 1990

Reason: Violation – Public Health Code

Name: Mario D. Santiago, MD, 4200 Fashion Square Blvd., Saginaw, MI 48603

Action, Date Taken: Suspended-120 days, Fined \$2,500, Reprimand; September 4, 1990

Reason: Unethical Business Practice

Name: Leslie G. Shawn, DO, University Village Shopping Center, 261 N. University, Pembroke, FL 33024

Action, Date Taken: License Voluntarily Surrendered; September 4, 1990

Reason: Criminal Conviction

Name: Sandra Marie Stritmatter, MD, 2926 Marshall, Ann Arbor, MI 48104

Action, Date Taken: Reprimand, Fined \$1,000, Probation two years, Earn 62 credit hours in addition to the 150 hours mandated for license renewal; June 3, 1990

Reason: CE Audit Violation

Name: Joseph J. Worzniak, MD, 1639 Davis Street, Wyandotte, MI 48192

Action, Date Taken: Reprimand, Fined \$1,000, Probation two years, Earn 100 credit hours in addition to the 150 hours

mandated for license renewal; September 16, 1990

Reason: CE Audit Violation

Name: Valeria Yashina, MD, 25 Haverhill Court, Ann Arbor, MI 48105

Action, Date Taken: Reprimand, Fined \$1,000, Probation two years, Earn 100 credit hours in addition to the 150 hours mandated for license renewal; September 8, 1990

Reason: CE Audit Violation

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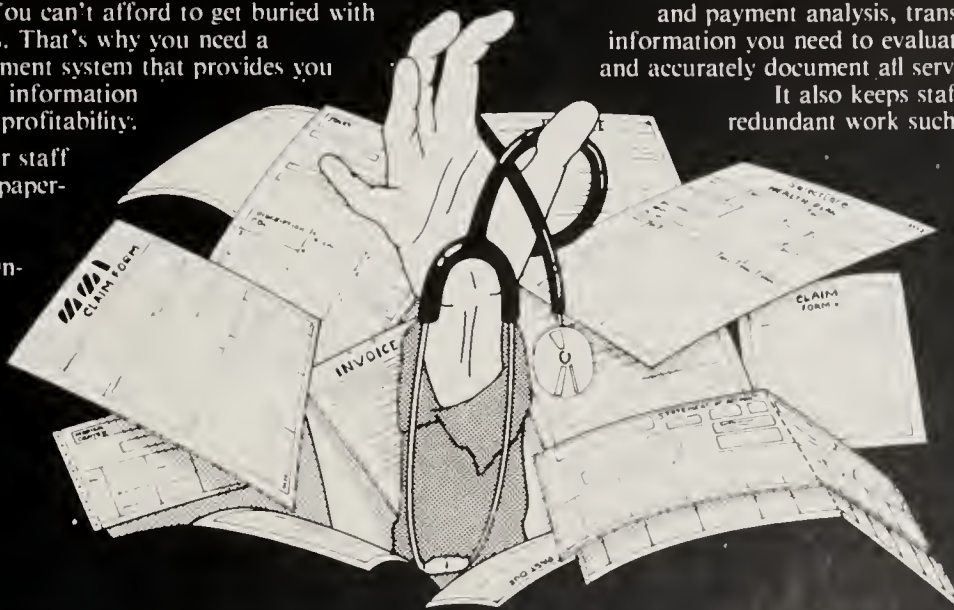
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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Bruce T. Adelman, MD — AN
1322 E. Michigan #103
Lansing 48912

Avery J. Aten, MD — FP
211 Long Rapids Rd.
Alpena 49707

Steven M. Benecke, MD — AN
5333 McAuley Dr. #R6115
Ypsilanti 48197

Marcus G. Blass, MD — GS
551 Linn St.
Allegan 49010

Douglas J. Boss, MD — FP
629 W. Shaw
Howard City 49329

Kathy J. Brittan, MD — FP
305 Oak St.
Paw Paw 49079

Benjamin J. Bryant, MD — GS
713 Capital Ave., SW
Battle Creek 49015

Julie K. Bush, MD — DR
7394 W. Bristol Rd.
Swartz Creek 48473

Donald E. Butler, MD — ORS
6343 Crane Rd.
Ypsilanti 48197

J.B. Chauncey, III, MD — IM/PUD
900 E. Michigan #105
Jackson 49201

Vicki H. Collins, MD — FP
6095 Wellesley Dr.
West Bloomfield 48322

Richard D. Conley, MD — PTH
7359 Deep Run Dr.
Birmingham 48010

Norman E. Coon, MD — CLP/PTH
2740 28th. St., SW
Grand Rapids 49509

Randal P. Desrochers, MD — GS
R-5016 P. O. Box 994
Ann Arbor 48106

Jennifer Ann Doyle, MD — GPM/OM
436 S. First St.
Ann Arbor 48103

Richard G. Faller, MD — EM
1105 Sixth St.
Traverse City 49684

Harvey J. Featherstone, MD — IM
3120 Professional Dr.
Ann Arbor 48104

Douglas L. Foster, MD — P
515 N. Michigan Ave.
Saginaw 48602

Gregory P. Gilmet, MD — PD
2522 Packard Rd.
Ann Arbor 48104

Ben L. Gold, MD — A
4870 Clark Rd. #203
Ypsilanti 48197

Gregory P. Gilmet, MD — PD
2522 Packard Rd.
Ann Arbor 48104

Orzie Henderson, Jr., MD — EM/FP
606 Brooks
Ann Arbor 48103

Scott A. Hotchkiss, MD — FP
2206 Mitchell Park #9
Petoskey 49770

Janet S. Hubert, MD — FP
610 Caring St.
Hillman 49746

Naomi J. Kagetsu, MD — D
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Mt. Clemens 48044

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Traverse City 49684

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Flint 48504

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512 Waverly Rd.
Holland 49423

Glen D. Libby, MD — PD
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Manchester 48158

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DEATHS

Gaylord S. Bates, MD *Dearborn*

Gaylord S. Bates, MD, a general surgeon, died July 17. He was 87. Doctor Bates attended Hiram College in Ohio before receiving his medical degree at Harvard Medical School in 1928. He served his internship and surgical residency at Harper Hospital in Detroit, before serving as a general surgeon from 1932-1973. Doctor Bates served 60 years as a physician in the Detroit Metro area. He was affiliated with Harper Hospital and Receiving Hospital, Detroit, Crittenton Hospital, Rochester, Veterans Hospital, Allen Park and Oakwood Hospital, Dearborn. He was a member of MSMS.



Max E. Dodds, MD *Grand Blanc*

Max E. Dodds, MD, a general surgeon, died July 10. He was 70. Doctor Dodds received his bachelor's and medical degrees from Wayne State University and interned at Woman's Hospital of Detroit. He completed his medical residency at Hurley Hospital followed by a three-year residency at Memorial Sloan-Kettering Cancer Center in New York City. He was among an initial group of doctors to come out of the famed New York facility with comprehensive training in cancer surgery and other treatments. He returned to Flint in 1953 where he established his surgical practice. He served as chairman of Hurley Hospital's surgery department from 1958 to 1963, director of surgical education from 1971 to 1975 and director of surgery from 1976 to 1978. He also served as chief of surgery at St. Joseph Hospital. Doctor Dodds was a pioneer in organizing the Flint medical community's battle against cancer, training half of Flint's surgeons. He also was the driving force behind the Greater Flint Area Community-Wide Hospital Oncology Program (CHOP), which was founded 10 years ago to set community standards for cancer treatment and to build a centralized registry of cancer cases. Doctor Dodds is credited with expanding the cancer care program at Hurley Hospital, into a diversified cancer center. He was awarded a Presidential Citation for life-time community service by the Genesee County Medical Society. He also was recipient of the MSMS Flag Award and the American Cancer Society Certificate of Merit. Michigan State University College of Human Medicine appointed him clinical professor of surgery in recognition of his professional skills and knowledge of surgery. His contributions to public health were recognized in resolutions and citations from Congress, the State Senate, the Genesee County Medical Society, the American Cancer Society and by Flint Mayor Matthew S. Collier, who declared May 15 "Max E. Dodds Day." He was an active member of the Ameri-

can Medical Association, the American Society of Clinical Oncology, the American College of Surgeons, the Michigan State Medical Society, the Flint Academy of Surgery, where he served as president, and the Genesee County Medical Society.

Nasser Froozan, MD *Plymouth*

Nasser Froozan, MD, a obstetrician/gynecologist, died July 1. He was 60. Born in Iran, Doctor Froozan was awarded his medical degree from the University of Tehran. While in Tehran, he co-authored many medical textbooks and papers used at the university. He moved to the United States in 1958 and began a rotating internship at Sibley Memorial Hospital in Washington, DC. He began his residency program in general surgery at Hazelton State Hospital, Hazelton, Pennsylvania. Later he pursued a residency at Alexandria Hospital, Alexandria, West Virginia; Columbia Hospital for Women, Washington DC; Crittenton Hospital, Detroit; and Timken Mercy Hospital, Canton, Ohio. Upon completing his residency, Doctor Froozan returned to Michigan to set up his practice in Westland, specializing in obstetrics and gynecology. He became increasingly active in infertility and AIDS awareness programs. He frequently lectured to students throughout the community. He was a practicing physician for more than 35 years and a member of MSMS.

Paul T. Chapman, MD *Grosse Pointe Woods*

Paul T. Chapman, MD, a public health physician, died July 27. He was 81. Doctor Chapman earned his bachelor of science and medical degrees from the University of Cincinnati. He interned at City Hospital Detroit, and served residencies at Maybury Sanitorium and Herman Kiefer Hospital. He was the medical director and city physician for Dearborn, retiring from this post in 1989 after 20 years of service. He formerly was director of tuberculosis control and medical director at Herman Kiefer Hospital. In addition, Doctor Chapman was a clinical assistant professor at Wayne State University, an instructor at the University of Michigan School of Public Health, senior consultant to the Tuberculosis Division of the Veterans Administration and a special consultant to the US Public Health Service. He was a member of the Wayne County Medical Society, the American Medical Association, the American Trudeau Society, and MSMS.

Jay C. Day, MD *Grosse Pointe Shores*

Jay C. Day, MD, a thoracic surgeon, died July 2. He was 84. Doctor Day received his medical degree from the Harvard Medical School in 1931. He served in the Navy from 1943-1946 as chief of thoracic surgery for three naval hospitals. Doctor Day served as an associate surgeon at Sinai Hospital and was a consultant of thoracic surgery at Bon Secours Hospital, Grosse Pointe. He also taught as an associate clinical professor of surgery at Wayne State University School of Medicine. Doctor Day was a founding member of the American Board of Thoracic Surgery and a member of MSMS.

Avis M. Olson (Middlebrook), MD *Lathrup Village*

Avis M. Olson, MD, a pathologist, died May 18. She was 63. Doctor Olson graduated from the University of Manitoba Medical School in 1952 and completed her residency at Detroit Mt. Carmel Hospital in 1956 and became an associate pathologist at the hospital. In 1985, Doctor Olson became Mercy's associate director of laboratories and director of the hospital's blood bank until her retirement in March 1989. She was a member of the Wayne County Medical Society and Michigan State Medical Society, as well as the American Medical Association. She was a fellow of the American Society of Clinical Pathologists, the College of American Pathologists and the International Academy of Pathology. Doctor Olson was an alternate delegate for the Michigan Society of Pathologists and a member of both the American and the Michigan associations of blood banks. She was a past president of the American Medical Women's Associa-

DEATHS

tion, Michigan Branch 20, editor of the Journal of the American Medical Women's Association in 1963, a former lecturer for the Michigan Society of Histotechnologists, education coordinator for the Mercy College medical technology program since 1973, and a clinical assistant professor of pathology at the Wayne State University School of Medicine since 1982.

Albert E. Quarton Jr., MD *Farmington Hills*

Albert E. Quarton, Jr., MD, an internist, died July 31. He was 76. A 1938 graduate of the University of Michigan Medical School, Doctor Quarton began his private practice in Royal Oak in 1948. In the 1950's, he was head of the medicine and diagnostic clinic at Beaumont Hospital, Royal Oak. In 1988 he marked his 50th year as a physician. A former vice-president to the Michigan Arthritis Foundation, Doctor Quarton was a member

of the Oakland County Medical Society, the American Medical Association and MSMS.

Renato G. Staricco, MD *Grosse Pointe Shores*

Renato G. Staricco, MD, a dermatologist, died May 14. He was 66. Doctor Staricco earned his medical degree at the University of Genoa. He trained as a resident in medicine at the Chesapeake & Ohio Hospital, Clifton Forge, VA, and Ford Hospital in Detroit. He then received a fellowship in dermatology at Wayne State and Detroit Receiving Hospital. He was associate professor of dermatology at Wayne State University School of Medicine. He was the recipient of the Michigan Dermatological Society Research Award in 1957. He retired from private practice in Lincoln Park in 1989. He was a member of the American Medical Association, the American Academy of Dermatology, the Michigan Dermatological Society, the Society for Investigative Derma-

tology, the Wayne State University Medical Society, and MSMS.

George A. Troester, MD *Monroe*

George A. Troester, MD, an allergist, died June 20. He was 87. Doctor Troester graduated from Wayne State University and the University of Detroit. He formerly had been on staff at Samaritan Center, Detroit, and Cottage House, Grosse Pointe. A medical doctor in Detroit for some 50 years, he retired in 1976. He was a member of the Wayne County Medical Society, the Michigan State Medical Society, the American Medical Association and the Michigan Medical Association.

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Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

October

10-12, A Symposium in Diabetes Care. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Registrar, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 936-9800. **Approved for:** 20 hours Category I Credit.

12, Basic Life Support for Health Professionals. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gwen Goldfarb, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 5 hours Category I Credit.

12-13, 14th Annual Michigan Fall Radiology Conference. **Location:** William Beaumont Hospital, Royal Oak, Michigan. **Sponsor:** William Beaumont Hospital-Diagnostic Radiology. **Contact:** Mary Anne Smith, Diagnostic Radiology, William Beaumont Hospital, 3601 W. 13 Mile Rd. Royal Oak, MI 48073, (313) 551-6064. **Approved for:** 14 hours Category I Credit.

13, Advanced Cardiac Life Support Recertification Course. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gwen Goldfarb, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 7 hours Category I Credit.

18, The Patient With an Automatic Implantable Cardioverter Defibrillator (AICD). **Location:** Eleanor N. Dana Center, Toledo, Ohio. **Sponsor:** Medical College of Ohio. **Contact:** Susan Hahn, Office of Con-

tinuing Medical Education, Medical College of Ohio, P. O. Box 10008, Toledo, OH 43699-0008, (419) 381-4237. **Approved for:** 3 hours Category I Credit.

18-20, 13th Annual Seminar in Diagnostic Ultrasound. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** The Registrar, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 14 hours Category I Credit.

24, Management Issues in Emergency Medicine. **Location:** St. Johns Hospital, Detroit, Michigan. **Sponsor:** Michigan Chapter, American College of Emergency Physicians. **Contact:** Kathryn M. Hopkins, Director, Michigan American College of Surgeons, 500 Lansing Road, Charlotte, MI 48813, (517) 645-8050. **Approved for:** 4 hours Category I Credit.

26, Annual Diabetes Conference. **Location:** Radisson Hotel, Lansing, Michigan. **Sponsors:** Ingham Medical Center, Department of Continuing Medical Education and Michigan State University, Department of Medicine. **Contact:** M.A. Taylor, Director, Office of Continuing Medical Education, Ingham Medical Center, Lansing, MI 48910-2819, (517) 334-2107. **Approved for:** 6 hours Category I Credit.

28-29, The Difficult Airway. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Anesthesiology. **Contact:** Julie Jacobs, Registrar, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 936-9800. **Approved for:** 13 hours Category I Credit.

November

1-2, Selected Topics in Clinical Nutrition: Cancer, Immunotherapy, Geriatrics, Obesity, and High Technology Nutritional Assessment. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Registrar, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 936-9800. **Approved for:** 10 hours Category I Credit.

2, Basic Life Support for Health Profes-

sionals. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gwen Goldfarb, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 5 hours Category I Credit.

3-4, Advanced Cardiac Life Support Provider Course. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gwen Goldfarb, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 16 hours Category I Credit.

5-6, Endothelial Cell Injury. **Location:** Eleanor N. Dana Center, Toledo, Ohio. **Sponsor:** Medical College of Ohio. **Contact:** Susan Hahn, Office of Continuing Medical Education, Medical College of Ohio, P. O. Box 10008, Toledo, OH 43699-0008, (419) 381-4237. **Approved for:** 12 hours Category I Credit.

8-9, Congenital Anomalies. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pediatrics and Communicable Diseases. **Contact:** Julie Jacobs, Registrar, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 15 hours Category I Credit.

8-9, Advanced Pediatric Life Support. **Location:** Children's Hospital, Detroit, Michigan. **Sponsor:** Michigan Chapter, American College of Emergency Physicians. **Contact:** Kathryn M. Hopkins, Director, Michigan Chapter, American College of Emergency Physicians, 500 Lansing Road, Charlotte, MI 48813, (517) 645-8050. **Approved for:** 14 hours Category I Credit.

9-10, 38th Annual Detroit Trauma Symposium. **Location:** Harper Hospital, Detroit, Michigan. **Sponsor:** Harper Hospital. **Contact:** Marjorie Norum, Department of Surgery, Harper Hospital, Detroit, MI 48201, (313) 745-2345. **Approved for:** 8.5 hours Category I Credit.

13-14, Child Abuse and Neglect. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, Towsley Center-

Finding the unknown . . .

Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 12 hours Category I Credit.

29, The Second Annual Modern Perinatal Problems. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 16 hours Category I Credit.

30, Psychiatry Update 1990. **Location:** Ritz-Carlton, Dearborn, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 11 hours Category I Credit.

December

1, Nutrition and Gastrointestinal Diseases. **Location:** Eleanor N. Dana Center, Toledo, Ohio. **Sponsor:** Medical College of Ohio. **Contact:** Susan Hahn, Office of Continuing Medical Education, Medical College of Ohio, P. O. Box 10008, Toledo, OH 43699-0008, (419) 381-4237. **Approved for:** 6 hours Category I Credit.

1, Psychiatry Update 1990. **Location:** Ritz-Carlton, Dearborn, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 11 hours Category I Credit.

1, The Second Annual Modern Perinatal Problems. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 16 hours Category I Credit.

6, Update in Cardiovascular Disease 1990. **Location:** Eleanor N. Dana Center, Toledo, Ohio. **Sponsor:** Medical College of Ohio. **Contact:** Susan Hahn, Office of Continuing Medical Education, Medical College of Ohio, P. O. Box 10008, Toledo, OH 43699-0008, (419) 381-4237. **Approved for:** 6 hours Category I Credit.



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MEETINGS

MSMS Meetings

October

9,10,11, MSMS/BCBS Medicare, (9th) – Amway Grand, Grand Rapids, MI. (10th) – To be announced, Bay City, MI. (11th) – Weber Inn, Ann Arbor, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

10, MSMS 1990 Risk Management Seminar, Amway Grand Plaza, Grand Rapids, MI. Contact: Jeanne Miller, Departmental Secretary (517) 337-1351.

17,18, MSMS/PSG, Retirement Planning, (17th) – Hyatt Regency, Dearborn, MI. (18th) – Amway Grand, Grand Rapids, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

23,24,25, MSMS/PSG, Advanced Coding, (23rd) – Dearborn Inn, Dearborn, MI. (24th) – To be announced, Lansing, MI. (25th) – Bay Valley Inn, Bay City, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

25, MSMS 1990 Risk Management Seminar, Holiday Inn, East Lansing, MI. Contact: Jeanne Miller, Departmental Secretary (517) 337-1351.

31, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

November

6,7,8, MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, MI. Contact: Sherry L. Fent, Chief, Physician Education (517) 337-1351.

13-16, MSMS/PSG/AMA, Office Staff Training, Hyatt Regency, Dearborn, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

AMA Meetings

October

10-12, Advances in Neuroscience: A Clinical Perspective. Contact: Dan Maier (312) 645-5382.

11-12, Ninth Annual AMA Science Reporters Conference. Contact: John Hammarley (312) 645-4417.

Michigan Specialty Society Meetings

October

11,18,25, Michigan Psychoanalytic Institute Discussion Series for Parents; Mid-Childhood. Contact: Michigan Psychoanalytic Institute, Extension Division (313) 559-5855.

17, Michigan League for Human Services, 78th Annual Conference. Contact: Gregory P. Conyers, Conference Coordinator (517) 487-5436.

25, Michigan Psychoanalytic Society, Freud and Canard Ferdinand-Meyer. Contact: John J. Hartman, Chairman (313) 559-5855 or (313) 557-8633.

November

1, Family Practice Research Day XIV. Contact: Michigan Family Practice, Talmage M. Holmes, Ph.D (517) 353-0772.

2,3, Beyond 2000: Teaching the Discipline and the Research Behind it. Contact: Michigan Family Practice, Douglas B. McKeag, MD, (517) 353-0772.

8,15,29, Michigan Psychoanalytic Institute Discussion Series for Parents; Adolescence. Contact: Michigan Psychoanalytic Institute, Extension Division (313) 559-5855.

17, Michigan Psychoanalytic Society, 16th Annual Symposium; Perversion and Object Relations; Sexual Misuse of Persons. Contact: John J. Hartman, Chairman (313) 559-5855 or (313) 557-8633.

National Specialty Society Meetings

October

7-11, American Academy of Family Physicians; Scientific Assembly. Dallas, TX. Contact: Beth Paulsen, Manager (800) 274-2237 ext. 4220.

7-12, American College of Surgeons; Annual Clinical Congress. San Francisco, CA. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

8-11, American Academy of Family Physicians; Annual Meeting. Dallas, TX. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

13-18, American Fertility Society Meeting. Washington, DC. Contact: (205) 933-8494.

14-17, American Neurological Association Meeting. Atlanta, GA. Contact: (612) 378-3290

15-19, American Society for Therapeutic Radiology & Oncology Meeting. Miami Beach, FL. Contact: (215) 574-3180.

19-23, American Society of Anesthesiologists. Las Vegas, NV. Contact: (708) 825-5586.

20-25, Congress of Neurological Surgeons; Annual Meeting. Los Angeles, CA. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

20-26, College of American Pathologists; Annual Fall Meeting. Dallas, TX. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

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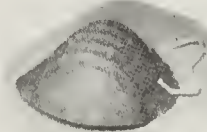
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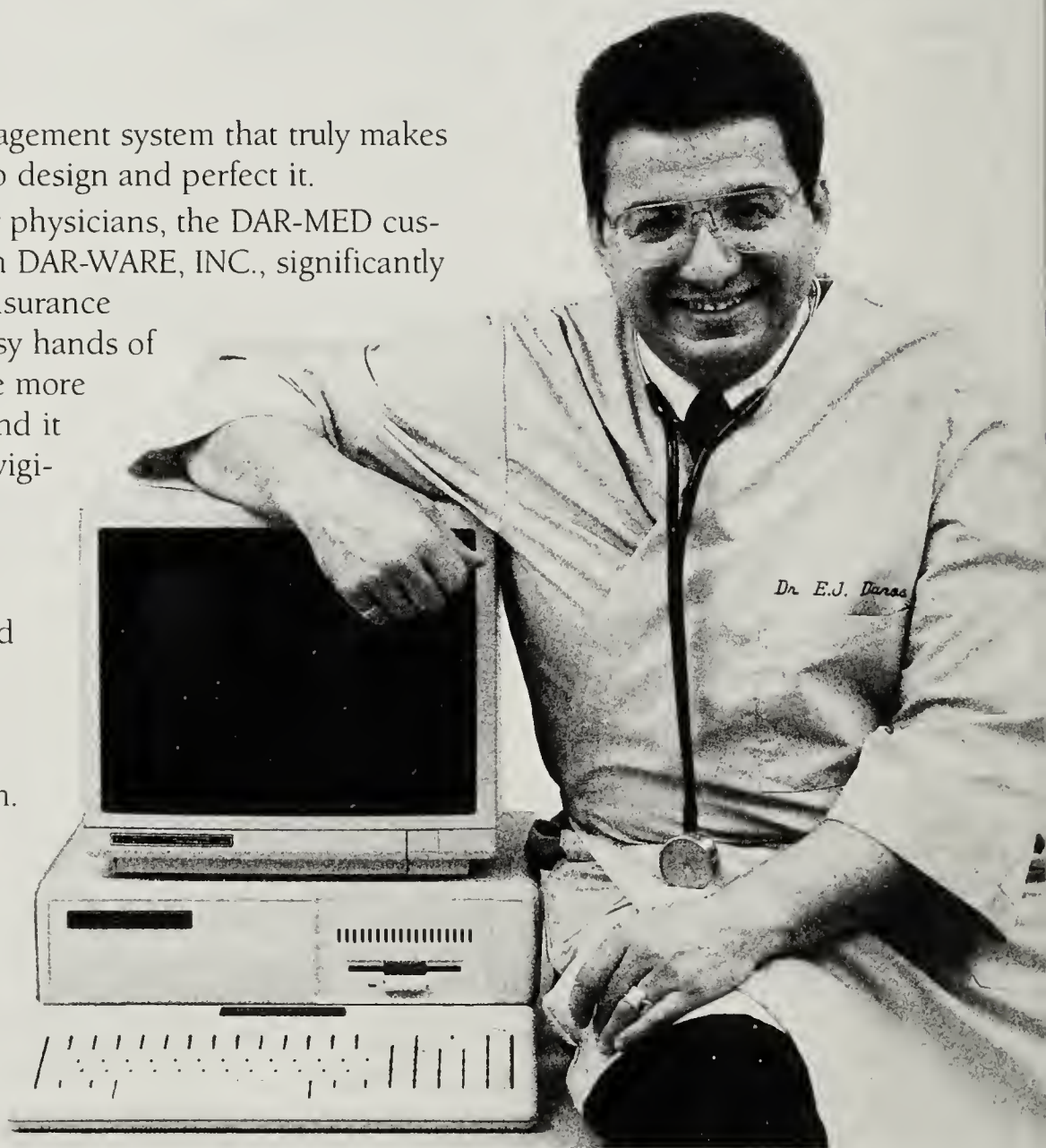
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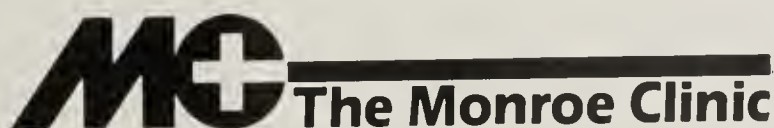
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PRESIDENT'S PAGE

A creative partnership between practicing physicians and local health departments could help everyone

By Susan H. Adelman, MD



A retired physician recently asked me whether I had any suggestions about how he could take care of needy patients, part-time, during his retirement without having to pay the premium for full professional liability coverage. A successful physician who is considering retiring told me that he just wants to be able to put in some time taking care of needy patients after he closes his present practice.

Many physicians tell me they would be willing to provide voluntary care for a few hours a week or month if they did not have to worry about professional liability insurance. The fear that holds them back, despite little or no available evidence to support it, is that poor patients will be more likely to sue them than wealthier patients.

When I recently represented MSMS at a meeting of the Michigan Association for Local Public Health (MALPH), I heard public health officers talk about how much they would like to have help from full or part-time physicians so they can deliver various programs. One example of a needed service is family planning instruction. Another example is prenatal care and obstetric care for low-income patients.

Burned out practicing physicians ask me often if there is any hope of their ever again regaining the joy they once felt in purely taking care of patients, without worries about malpractice suits or bureaucratic harassment over their fees. Patients with low incomes who do not qualify for

Medicaid or who qualify for Medicaid but have few nearby physicians who take Medicaid, tell us they have few choices available for medical care.

Perhaps there is an answer to these questions. Raj Wiener, director of the Michigan Department of Public Health, is looking into ways of obtaining professional liability protection for physicians committed to taking care of needy patients. Certainly the easiest to cover is the physician who is retired, but who would be willing to work part-time for a local public health department. These physicians could be treated as employees of the department, and insurance for this setting could only be furnished through the department. If they wanted a practice on the side, this insurance would not be available to them, since the insurer would not want to get stuck with an additional unquantified risk.

The situation would be different for the physician who wants coverage for voluntary or paid services rendered under the auspices of a local public health department, but who wants to continue in private practice. Michigan insurers have not been willing up to now to exclude one segment of a physician's activities, while they continue to cover the rest. If this could be accomplished, then the physician would need to purchase coverage for private practice activities only, and the health department would have to arrange coverage for their services performed for its clients. Whether these services would have to be rendered within a public health clinic setting or whether they could be delivered through arrangements with their offices would remain to be determined. The matter of compensation for their services also would have to be worked out.

Public health officers assure me that they do not have the resources to deliver regular patient care. They would prefer to have practicing doctors give the care, so they could use their efforts on problem identification and solving, both for the health care needs of the general population and for the special needs of the poor.

What public health officers need is for

us to give the patient care. What practicing physicians need is a way to care for the poor without putting ourselves in undue financial jeopardy, in danger of a ruinous suit, or in the position of transforming our whole practice into a Medicaid or uncompensated care practice. Nobody can afford this!

A creative partnership between practicing physicians and local health departments could help everyone. Obstetric care for Medicaid patients could become available again if obstetricians were insured as public health officers for these patients. Physicians who are burned out or ready for retirement could find a new lease on life through practicing in a new venue, and meeting new challenges with the benefit of a lifetime of medical experience under their belts. They might even end up making a full-time career change. Some of our colleagues have done so, and they now report great job satisfaction. Those of you who might be interested should ask some who have done it.

Before MSMS or the MDPH approaches the insurance commissioner to seek these alternate insurance arrangements, could those who are interested in working part-time with your local health department, if liability insurance were furnished, please give MSMS your names? Would those who are retired physicians who might be interested, or who are physicians doing purely administrative work who would be interested in doing part-time work for the health department if liability insurance were covered, please also contact MSMS, so we will know how many of you are out there?

The more of you who call us, the greater the likelihood we will be able to obtain the modified coverage necessary to give you this opportunity. Please call. This is potentially a win-win program for everyone. It certainly beats turning our whole health care system on its head to solve the problem of health care for the poor and uninsured, which is what many members of society propose doing today. ■

Doctor Adelman is MSMS president.

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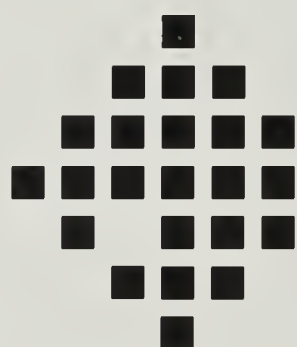
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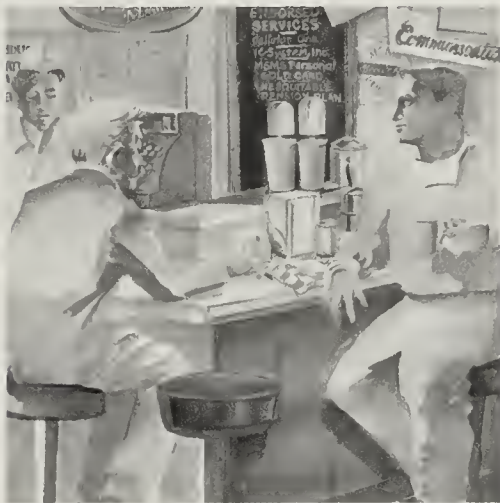
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14 COVER STORY

MSMS offers its members many benefits. That is the message of Dorothy Kahkonen, MD, chairman of the MSMS Committee on Membership Recruitment and Retention. That also is the message of this month's cover story, which begins with a letter from Doctor Kahkonen. Following her letter, this month's cover story features a variety of demographic information; an indepth report from MSMS Treasurer Billy Ben Baumann, MD, on the MSMS budget, the dues increase and financial goals for the year ahead; a letter from the MSMS Auxiliary membership chairman; a complete list of all MSMS committees; a list of component medical societies and contacts; an examination of the value of county medical society membership and AMA membership; two charts which show how the AMA and MSMS works; and finally, a list of whom to call at MSMS.



Page 14

F E A T U R E S

39 1991 PHYSICIAN SERVICE GROUP SEMINAR SCHEDULE

41 YEAR-END TAX SAVING STRATEGIES

This article explores a variety of tax-saving strategies for physicians.
— BY JULIUS GIARMARCO

45 MSMS ISSUES STATEMENT ON PHYSICIAN-ASSISTED SUICIDE

The MSMS Board of Directors adopted a statement on physician-assisted suicide at its September 19, 1990 meeting at MSMS headquarters. The statement is featured in its entirety.

47 MSMS PUBLIC AFFAIRS/LEADERSHIP CONFERENCE

Photo highlights.

51 OREGON BASIC HEALTH SERVICES PROGRAM

John Kitzhaber, MD, president of the Oregon Senate, visited MSMS headquarters in September to discuss Oregon's Basic Health Services Program. Highlights of his presentation are offered in this photo feature.



Page 47

D E P A R T M E N T S

5 In My Opinion

"Physicians must assume an active role in helping shape our health care system"
BY MARGUERITE SHEARER, MD

7 Letters

9 Newsfronts

10 Physicians in the News

55 New Members

59 Deaths

61 Meetings

65 Category I Courses

69 Classifieds

72 Advertising Index

74 President's Page

"The word for the future is data"
BY SUSAN H. ADELMAN, MD

Also included in this issue:

The MSMS Annual Scientific Meeting official program. Pull out this 40-page program and take it with you to the MSMS Annual Scientific Meeting, Nov. 6-8, at the Hyatt Regency Dearborn, or save it for handy reference.

In next month's issue of *Michigan Medicine*:
Living wills.
Cover illustration by: Robert L. Brent.

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IN MY OPINION

Physicians must assume an active
role in helping shape our health care system

By Marguerite Shearer, MD



state medical assistance.

Our health care system is in a period of transition, still ostensibly committed to universal access; but now the driving force is economic factors, whereas the forces in the '60s and '70s were primarily social. A major question is... what role will the medical profession assume in shaping the change? If escalating health care costs are a symptom, we must address the etiology of the "disease." The problem has to do with the widening gap between social expectations and society's willingness and ableness to pay.

As long as people and providers can consume resources using everyone else's credit cards, the health consumption deficit will grow proportionately. As long as physicians and hospitals continue to receive payments from the same credit card pool for services having no documented effect on improving health status and/or eliminating ill health, control of costs will elude management by payors.

Physicians need to assist in the definition of a clear and equitable policy upon which to base the allocation of limited health care dollars in addition to the development of practice guidelines concerning appropriateness of care. It has been repeatedly said that if unnecessary and inappropriate care were eliminated there would be enough dollars to provide care for everyone. I'm not sure about that, but I do believe it would make a very significant contribution. I salute Doctor Kitzhaber and the other physicians in Oregon who have worked so diligently at addressing the problem in their state and for their ability to forge the political consensus that has resulted in the success they have achieved. I now hope they will be given the opportunity to implement their plan. We will all learn from their pioneering work. ■

Doctor Shearer is a member of the MSMS Board of Directors and the MSMS Committee on Publications.

At the September MSMS Board of Directors meeting we had the opportunity to discuss access to health care issues with John Kitzhaber, MD, an emergency room physician who is also president of the Oregon Senate. The Oregon legislature, working with the active support and leadership of the medical community, is addressing the access problem of those who have no health insurance or are underinsured. Doctor Kitzhaber decried the hypocrisy of castigating various attempts to address health care resource allocation as "rationing" when indeed we already ration care and have been doing so for some time! Webster defines rationing as "...to distribute equally" and "...to use sparingly."

Certainly the number of people who do not avail themselves of basic and, at times, urgent medical care for financial reasons, and providers who refuse to see Medicaid patients are examples of the rationing that exists today. The government actively "rations" when it determines who is eligible for Medicaid; in Michigan, the eligibility is set generally at 67 percent of the federal poverty level; for pregnant women and children under six, the level is set at 185 percent of the federal poverty level.

Nationally, the average state Medicaid eligibility level is less than the federal poverty level, thus there are many people whose income places them within the federal poverty level that are not covered by

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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Letters from Our Readers

Laparoscopic cholecystectomy is here to stay

Finally a new excitement in general surgery has occurred. Every surgeon is hustling to sign up for a course on this new technique, and eager to start performing it. I am talking about laparoscopic cholecystectomy.

This technique was started in Europe by Doctor F. Dubois in May 1988, as far as I can find in the literature, followed by Doctor E. Reddick in the USA. In the past, many have tried to perfect this method on animals, but not until recently with the advent of better fiberoptic and video equipment has this technique become feasible.

After performing more than 240 laparoscopic cholecystectomies since November 1989, I can say that this technique is here to stay. The patients are ecstatic about it and cannot believe that it could be done; especially, when they compare their four small stab wound incisions to the one large cut that their friends, who had it done the traditional way, have. They talk about their overnight hospital stay, the minimal pain they had and their return to full activity and work in one week with laparoscopic cholecystectomy, compared to the five to seven hospital days, the muscle pain with every breath and the four to six weeks recovery period with the old way.

Several other advantages are obvious using this method, compared to the conventional way, including less atelectasis due to less pain, especially in patients with COPD; less deep vein thrombosis and pulmonary embolism, because of early and easy mobility; less chance of wound infection and incisional hernia, due to the small stab wounds. Finally the decreased handling of the bowel results in less ileus so that patients are able to return to a regular diet within 24 hours; also this results in less abdominal adhesions which decreases the potential for future bowel obstruction.

I went through a learning experience, which every surgeon will have to go through; adapting to new instruments, getting used to working off a video moni-

tor and developing a new eye hand coordination. This learning curve was obvious in the first 25 cases, and was manifested by a decreasing operating time and number of complications with experience.

Some of these complications that I had at the beginning required open procedures. Some patients stayed longer than one day, usually for nausea or pain. However, I have not denied this approach to any patient who qualified for elective cholecystectomy, regardless of weight, previous abdominal surgery, size or number of stones. The operative time for this procedure was longer than the conventional method initially, but this was counterbalanced by less post-operative morbidity, especially in heavy patients. The heaviest patient to have this operation was 310 lbs. He was discharged home in 48 hours and returned to work after one week. Several patients were discharged after eight hours of their operation. The operative time now is equal to the conventional method. Difficulties encountered resulting in an open procedure occurred in less than two percent. There has been no operative mortality.

After I felt comfortable with this technique, I started to perform this operation on high risk patients with acute cholecystitis, even gangrenous cholecystitis and empyema of the gallbladder, with gratifying post operative results. Epidural anesthesia has been used on three patients due to their increased cardio-pulmonary risk factors.

The laser is not what made this operation, but definitely it caused a special ringing in the public's ears. It also made some insurance companies deny approval for their patients, ignoring what the patient could gain from the technique. One of the insurance carrier's fears was that the hospital charges for the laser were exorbitant. In addition they are labelling the procedure as experimental.

This procedure is neither experimental nor does it need the laser. I prefer to use the laser because it causes less smoke in the field and offers better cutting. However, it has been done with the electrocautery alone when the laser failed during the

operation. In addition, several surgeons on the West Coast are doing it in the latter way without a problem.

In the future, we will see a lot of new developments in laparoscopic techniques with regard to instrumentation and also expansion of their use to other surgical areas, i.e., appendectomies and herniorrhaphies.

I believe we will see a time when insurance companies and employers will ask for a reason to perform a conventional cholecystectomy when the laparoscopic technique is available.

Finally, we have to keep in mind that patient safety and well being is what we all strive for, and surgeons who are taking up this technique should be especially careful in performing their first cases. Further, institutions should adapt a credentialing policy to assure the safety of their patients and to monitor results carefully.

*AbdelKader Hawasli, MD, FACS
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MEDICAL NEWSFRONTS

INDEX

U-M to receive \$10.5 million to study retirement issues	9	Sexual assault services directory and guide available	10
New information available on anti-HIV drug	9	Pain management in children still in the "dark ages," U-M reports	11
Blues propose program for uninsured kids	9	Blues donate \$5,000 to state AIDS fund	12
Incontinence a "common, yet hidden" problem for women, U-M reports	10		

U-M to receive \$10.5 million to study retirement issues

The University of Michigan Institute for Social Research (ISR) will design and conduct a long-term study of health and retirement issues in collaboration with the National Institutes of Health.

The study, projected to continue for at least 12 years, is estimated to cost approximately \$10.5 million over the first five years and is one of the largest awards ever received by ISR. The U-M researchers plan to interview a sample of approximately 8,000 US families and more than 13,000 men and women in sample families.

Planning for the study will begin immediately, with the first phase of data collection scheduled to begin in early 1992.

According to F. Thomas Juster, ISR research scientist and professor of economics who will direct the study, "We plan to provide data on retirement patterns that are crucial to understanding the health and economic issues confronting policy-makers during the next several decades, when the US population will be aging rapidly."

The ISR study design, which was selected by the NIH in a

competitive process, will provide current information on the labor force activity, health status, and family responsibilities of men and women approaching retirement.

New information available on anti-HIV drug

By mid-July 1990, more than 10,000 patients with AIDS or ARC had received ddI, an experimental anti-HIV drug, through either Phase II clinical trials supported by the National Institute of Allergy and Infectious Diseases (NIAID) or through an expanded access program initiated by Bristol-Myers Squibb Co. Although well tolerated overall, ddI produces some toxicities; pancreatitis has been reported in 1.5 percent of patients enrolled in the Phase II trails and in two percent of patients enrolled in the expanded access program. The risk of pancreatitis appears to be strongly correlated with prior history of pancreatitis and with advanced HIV disease and poor clinical status.

NIAIDs of Bethesda, MD, has prepared a Note to Physicians detailing specific precautions for doctors to consider to decrease the risks of pancreatitis, along with a

description of other side effects. The ddI Note to Physicians and information on the ddI and other AIDS studies can be obtained by contacting the AIDS Clinical Trials Information Service (ACTIS) at 1-800-TRIALS-A.

Physicians are strongly encouraged to consider referral of eligible patients to the ddI controlled clinical trials, whose completion is essential for a full understanding of ddI's long-term safety and efficacy in treatment of HIV infected patients.

Two of the Phase II trials compare the safety and efficacy of ddI and AZT in AIDS or ARC patients, and a third evaluates ddI in AIDS or ARC patients intolerant to AZT. The trials are conducted by NIAID's AIDS Clinical Trials Group (ACTG).

Bristol-Myers Squibb Co. is offering an expanded access program to provide ddI to patients with HIV who are ineligible for the Phase II trials. More information on this program is available through the company's VIDEX Information Center at 1-800-662-7999.

Blues propose program for uninsured kids

The Blue Cross and Blue Shield of Michigan (BCBSM) Board of Directors has approved a plan to provide free health care coverage to the neediest of an estimated 34,000 uninsured children in Michigan.

Richard E. Whitmer, BCBSM president and chief executive officer (CEO) explained that the plan would be underwritten by contributions from community, religious and business organizations, as well as individuals.

He said the fundraising efforts are expected to produce about \$300,000 the first year — enough to provide coverage for 1,200 youngsters for one year.

BCBSM will donate the administrative services including claims processing, Whitmer said.

The plan, called the "Caring Program for Children," would be open to youngsters through age 13 who are in families with household incomes at or below the Federal poverty level and not eligible for Medicaid or other government-sponsored health care programs.

The coverage would stress preventive care. It would pay for office visits, including immunizations, and outpatient services. It would not pay for inpatient hospital care because it is provided to poor children through other programs.

The proposed benefit package would cost an estimated \$21 per month per child.

The plan needs the approval of the state Insurance Commissioner as well as changes in BCBSM regulatory law before it can go into effect. Whitmer said the earliest it could be operational would be April 1 of next year.

He said further details on the program, including how families could enroll, would be announced later.

He urged persons to avoid telephoning BCBSM at this time about the program.

Benefits of the proposed program will include:

Physician office visits for checkups, immunizations and treatment of illness; outpatient diagnostic services, surgery and substance abuse treatment; and accident and medical emergency care.

There will be no exclusion for pre-existing conditions.

The program will be sponsored and managed by the Michigan Health Care Education and Research

Continued on page 10

Continued from previous page

Foundation, a 501(c)(3), non-profit subsidiary of BCBSM.

The Foundation will set up a broad based, 30-person committee representing parents of sponsored children, large and small BCBSM customers, labor, government, medical, social welfare, business, community and religious organizations to oversee operating policy for the plan.

The Michigan Department of Social Services has submitted a request to the Health Care Financing Administration (HCFA) to fund a three-year pilot program in two specific areas of the state that would include an expanded Caring Program for Children.

No decision has been announced on that request.

Incontinence a "common, yet hidden" problem for women, U-M reports

Incontinence, especially during certain types of exercise, is an "overwhelmingly common, although still hidden problem" for many women of all ages, according to a recently published study by University of Michigan Medical Center researchers.

Of 326 gynecology patients surveyed (average age: 38.5), 47 percent reported involuntary leakage of urine during everyday situations, such as coughing, sneezing, lifting, moving furniture, vacuuming and lawn mowing. Thirty percent noted incontinence during at least one type of exercise; activities involving repetitive bouncing, such as jogging and high-impact aerobics, were associated with the highest level of leakage.

The biggest predictor of incontinence appears to be the woman's childbearing history; the more vaginal deliveries a woman has, the more common

the problem, according to co-investigator John O. L. DeLancey, MD, assistant professor of obstetrics and gynecology. However, 14 percent of women with no childbearing history also noted exercise-related incontinence.

Despite the inconvenience of involuntary urine leakage, most of the women surveyed appeared to be very adaptive to the problem; more than half said they wear a sanitary pad during exercise, while only 20 percent reported ceasing related athletic activities.

However, only 35 percent discussed their incontinence with a physician or nurse.

"This lack of disclosure raises several issues," Doctor DeLancey says. "First and possibly foremost, many physicians do not attempt to elicit the presence of incontinence in their patients. Second, women often are embarrassed by or ashamed of this problem. The lack of discussion...leads them to believe that theirs is a unique and strange problem...an increased awareness may lead women to seek advice about what would otherwise be considered an annoying and embarrassing, but normal, part of life."

Surgical and nonsurgical interventions could eliminate or reduce incontinence and improve the quality of daily life for these women, as well as remove a possible obstacle to the benefits of exercise, Doctor DeLancey says.

Sexual assault services directory and guide available

An updated *Sexual Assault Services Resource Directory and Guide* is available from the Sexual Assault Information Network of Michigan. First published in 1984, the directory's third edition

Continued on page 11

Physicians in the News



Federico G. Mariona, MD, Southfield, is the new chairman of the Michigan Section of The American College of Obstetricians and Gynecologists (ACOG). His three-year term began in October. A maternal-fetal specialist, Doctor Mariona is also director of maternal-fetal medicine at Oakwood Hospital. In addition, he is professor of Ob/Gyn at Wayne State University.

Joseph C. Honet, MD, chairman, Sinai Hospital Department of Rehabilitation Medicine, was recently selected as the 23rd Walter J. Zeiter Lecturer by the American Academy of Physical Medicine and Rehabilitation. This prestigious lecture, which relates to the history of physical medicine and rehabilitation, is presented annually to the physiatrist who exemplifies the qualities of statesmanship, scholarship, executive leadership and warm friendship. Doctor Honet presented his lecture, "Graduate Medical Education: Does Form Follow Function?" during the Academy's award luncheon October 24 in Phoenix, AZ.

Albert A. Kuhn, MD, Bloomfield Hills, and his wife Peggy, are the recipients of Hutzel Hospital's 1990 Ellen G. Martin Award for Humanitarian Service. Named in memory of the late Hutzel

board member, Ellen Grinnell Martin, the award is presented to an individual or individuals who have shown outstanding dedication to both the hospital and the Detroit community. Doctor Kuhn, an internal medicine specialist, retired September 28 after more than 30 years of service to the hospital and over 50 years in the medical profession. He is credited with playing an active role in the growth of Hutzel Hospital. Doctor Kuhn is a member of the Wayne County Medical Society and the Michigan State Medical Society. His wife Peggy is a member of the MSMS Auxiliary.

S. Jan Behrman, MD, was recently honored by a "Who's Who" of national and internationally renowned experts in reproduction and fertility during a scientific symposium sponsored by William Beaumont Hospital. Doctor Behrman has been a figure of national and international prominence in the field of reproduction and endocrinology since 1949 when he joined the faculty of the University of Michigan as a professor of obstetrics and gynecology. He joined the staff of William Beaumont Hospital in 1977 serving as chief of the department of obstetrics and gynecology and later as director of In Vitro Fertilization and the hospital's reproductive fellowship programs. He currently serves as medical director of the Beaumont Fertility Center.

Thomas W. Schacht, MD, is the new chief of staff of the Ada B. Vielmetti Health Center at Northern Michigan University. A Marquette native, Doctor Schacht had spent the past five years as a senior staff physician at Detroit's Henry Ford Hospital.

Continued from page 10

includes sections on Michigan's criminal sexual conduct statute, the rights of survivors, and a bibliography, in addition to a listing of service providers throughout the state. It is available at no cost, thanks to a grant from the Office of Children and Youth Services, Department of Social Services.

To order, send your name, name of organization, full address, and telephone number to S.A.I.N., PO Box 20112, Lansing, MI 48901. One copy per organization only.

Pain management in children still in the "dark ages," U-M reports

Pain often isn't assessed, managed properly or acknowledged by health care professionals, especially when the patient is a young child or a baby who cannot verbalize how much he or she hurts, according to David Rosen, MD, assistant professor of anesthesiology and instructor of pediatrics and communicable diseases at the University of Michigan Medical Center, Ann Arbor.

"Pain management in children is still in the Dark Ages," he says. "Pain has been around since the beginning of time, and yet it is an issue that the medical profession has done the worst job dealing with."

"Many surgeons still maintain that children don't feel pain, which is a lot of bunk," he says. "Studies have shown that infants have the appropriate mechanisms for feeling pain. There is every evidence that infants and young children do feel and experience pain much like an adult does," he says.

Despite such evidence, studies indicate that children in many of the nation's hospitals are getting significantly less pain medication for the same procedures as adults (adjusting for height and

weight), and infants often are receiving minimal or no analgesia for invasive operations ranging from circumcision to heart surgery.

Doctor Rosen cites a study published in 1983 by University of Colorado pain researcher Judith E. Beyer, RN, PhD. The study, published in the journal *Pain*, compared the postoperative prescription and administration of pain medication following cardiac surgery for 50 children and 50 adults. During the five-day postoperative observation period, children received 30 percent of all pain medications that were prescribed, while adults received 70 percent. Even more dramatic, 12 children — all infants and toddlers — never received any analgesics while hospitalized during their first three days after surgery.

The work of Beyer and other pain researchers in uncovering what Doctor Rosen feels is the tip of the iceberg. "The bottom line is that caregivers in general are uncomfortable with pain management in children," he says. "Patients' charts don't reflect a consistent monitoring of comfort measures or pain assessment by nurses or physicians. Nobody makes pain management a priority; nurses don't do it and doctors don't do it."

The widespread reluctance to acknowledge pain in children perhaps is an attempt to justify largely-unfounded fears about side effects associated with narcotic pain relief, such as drug addiction and respiratory failure, Doctor Rosen says.

Blues donate \$5,000 to state AIDS fund

Blue Cross and Blue Shield of Michigan (BCBSM) has given a combined \$5,000 contribution to the Council of Michigan Foundation's Michigan AIDS Fund on behalf of BCBSM and the four Blue Care Network health maintenance organizations.

Michigan State Medical Society

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100.1+	13.6¢/min.	11.6¢/min.	10.9¢/min.



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Dear Colleague:

As chairman of the MSMS Committee on Membership Recruitment and Retention I am frequently asked the question, "What has MSMS done for *me* lately?" To that I say, plenty.

MSMS is the largest, most comprehensive, most effective organization in the state representing the interests of physicians and patients. It was founded in 1866 and has served medical, educational, political and socioeconomic needs continuously since that time. It is truly a democratic organization. County medical societies and state specialty societies provide delegates to the MSMS House of Delegates, which meets once a year to hear testimony, study reports and resolutions, and establish policy by majority vote. The MSMS Board of Directors, elected by the House, oversees, interprets and implements actions based on House of Delegates policy, and is responsible for the day-to-day operations of MSMS.

Yea, but what have they done for physicians lately, you ask? Here are a few answers I hope you will share with your colleagues who are not members.

MSMS has:

- *Defeated Mandatory Medicare Assignment*, not once, but twice in the Michigan House of Representatives. MSMS is strongly opposed to this legislation and has testified numerous times before the House Committee on Public Health. MSMS also is assisting county medical societies in developing voluntary assignment programs in lieu of mandatory assignment legislation.

- *Acted in an advisory capacity to Blue Cross Blue Shield of Michigan (BCBSM)* throughout the writing of the new BCBSM contract, and has published information about the contract prepared by BCBSM and MSMS officials. MSMS continued to keep members aware of BCBSM development through a series of fall seminars. MSMS will proceed in its role as educator and advisor to BCBSM.

- *Defeated repeated legislative attempts to expand the scope of practice for allied health professionals.*

- *Acts as an ombudsman of physicians with complex reimbursement problems, resolving complaints,*



cutting through red tape and getting real solutions.

■ *Organized physicians who will participate with legal experts and law enforcement officials to examine the consequences of drug abuse with Detroit elementary school children in a series of seminars.*

Medicine today is full of challenges and uncertainties. But by joining together we can ensure a quality health care environment for our patients and our families. MSMS makes a difference as the voice that represents organized medicine on political and legislative issues in both Lansing and Washington, DC. MSMS plays a vital role in educating the public on health issues that concern all of us, such as AIDS, health insurance, drug abuse, the environment and breast cancer.

The primary purpose of MSMS is to represent and defend the interest of physicians practicing in Michigan and to promote the science and art of medicine so that physicians may better serve patients and the public health. The basic objective of MSMS is to improve the health of Michigan residents.

We are, indeed, blessed with outstanding leaders

at every level of organized medicine. Our leaders are dedicated, travel many miles, and spend hundreds of hours representing us, willingly making physical, family and economic sacrifices. Their only reward is the satisfaction of using their resources and skills on behalf of their patients and colleagues, quite often without any acknowledgements of their efforts.

We need more support for our leadership and more commitment, service and backing on all levels of organized medicine. MSMS is continually recruiting new physicians to help meet the challenges of medicine. I am asking physicians in this state to remain members of organized medicine at all levels. Encourage a non-member to join us in our efforts. It is our responsibility to promote the idea of membership and to persuade the non-member to join us in making this a truly united body of physicians. ■

*Dorothy Kahkonen, MD
Chairman,
MSMS Committee on Membership
Recruitment and Retention*

MSMS

MEMBERSHIP

DEMOGRAPHIC

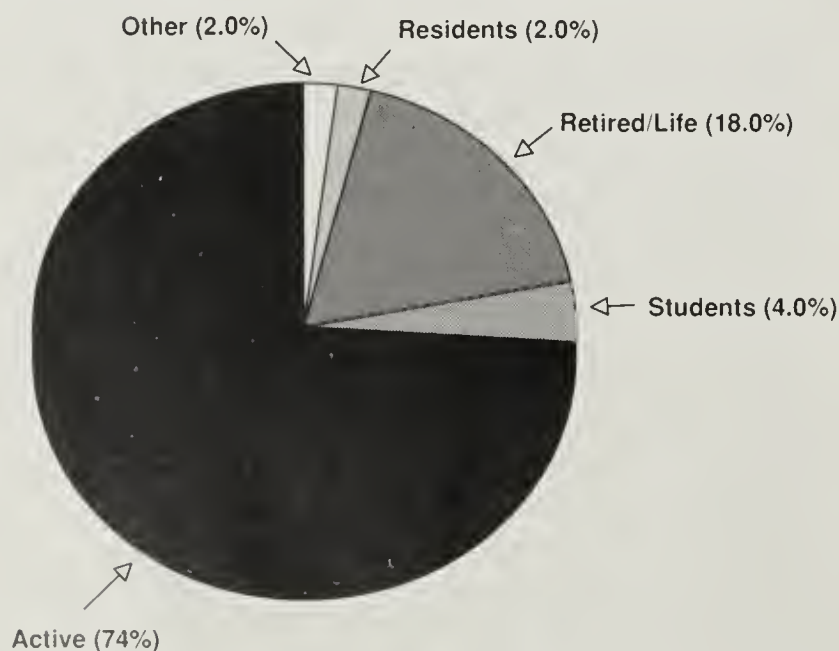
INFORMATION

The following data represent a picture of current MSMS membership. The charts and graphs include information regarding the following:

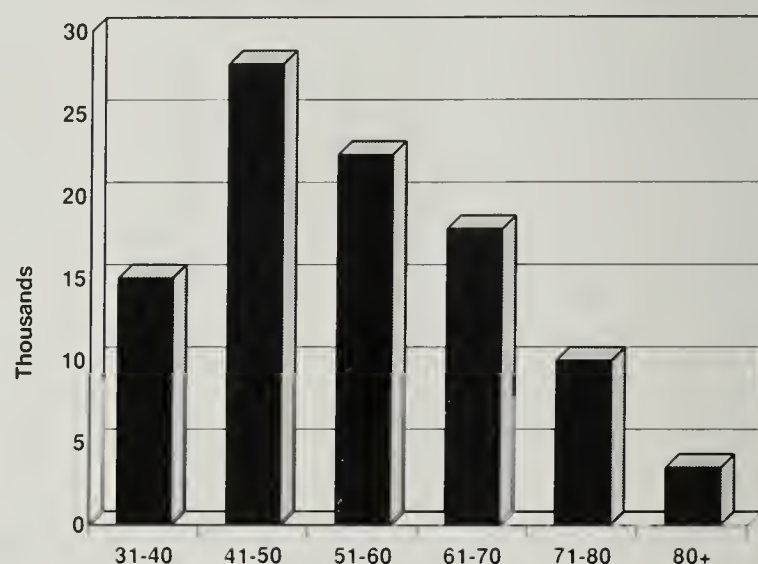
- Member distribution by class
- Membership by age group
- Membership distribution by gender
- International medical graduates
- Membership specialty distribution

The Department of Membership Recruitment and Retention presents this data for your information. If you have any questions regarding the information, please contact MSMS.

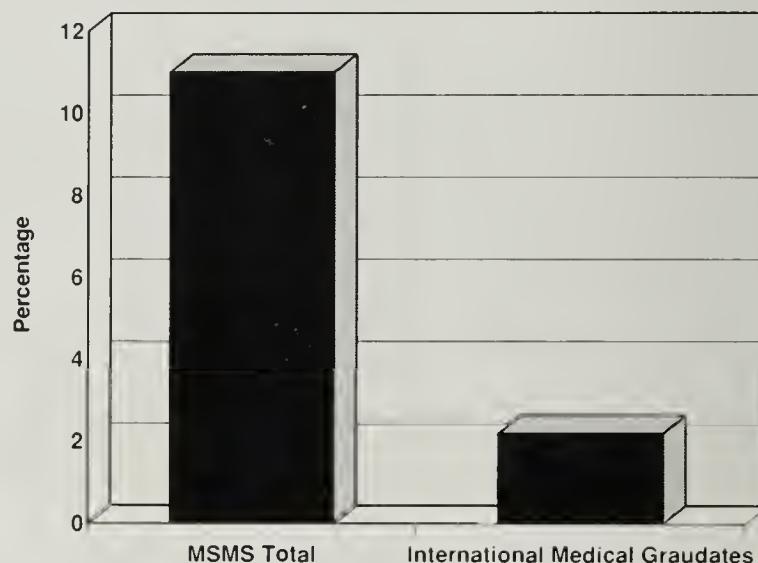
Member Distribution by Class



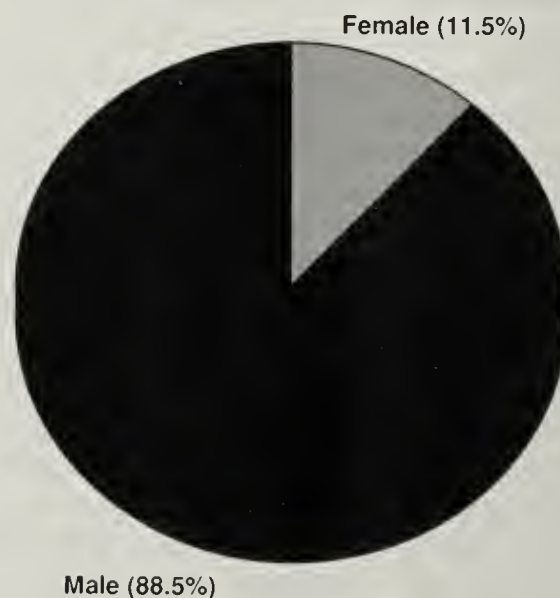
Membership by Age Group



International Medical Graduates



Membership Distribution by Gender



MSMS Treasurer Billy Ben Baumann, MD addresses budget, dues increase

By Claudia Skutar

Last May, the MSMS House of Delegates voted at its annual meeting to increase MSMS membership dues by \$90 for a three-year cycle between 1991-1993. Beginning in 1991, dues will increase to \$440 for that three-year period. Dues for the three-year cycle from 1987-1990 were \$350. In the following interview, MSMS Treasurer Billy Ben Baumann, MD, Oakland County, explains both the rationale behind the increase and its importance to maintaining an effective medical society.

Question: Why does MSMS need a membership dues increase?

Doctor Baumann: In the next three to five years, physicians will face some of the strongest challenges ever — both to organized medicine and to their individual practices. Experience has proven over and over that the best way to face these challenges is with a unified and organized membership backed with energy and reserves, including monetary resources. The increasing and shifting costs of health care, problems with reimbursement, liability concerns, and the skyhigh costs of malpractice insurance, to name just a few issues of importance to physicians, require a solid financial core for representing physicians' views. The MSMS dues increase will help us to maintain that financial core and meet the challenges.

Question: How does MSMS spend its money?

Doctor Baumann: Here's a breakdown of the \$5.65 million MSMS budget:

- 36 percent state-federal lobbying/third party payer representation
- 19 percent physician advocacy
- 19 percent education of physicians/public
- 15 percent MPRO/hospital relations
- 7 percent member communications
- 4 percent legal representation

The greatest amount is spent on lobbying for physician input on state and federal legislation. Because urgent issues in a number of health care-related areas have caused a tremendous increase in recent years in legislation designed to deal with the problems, our lobbying budget has increased so that we can effectively track and provide input on all legislation that would affect physicians.

Question: How does MSMS compare with other state medical societies in the dues it charges its members?

Doctor Baumann: Michigan is the eighth largest state in the country, both in terms of the size of its population and the size of the state medical society's membership. Through 1990, 25 states ranked the same or higher in the membership dues charged by their medical societies. (See chart below.) However, MSMS has a reputation for being one of the most active state medical societies in the country. We've communicated with other state societies and discovered that in proportion to the volume of MSMS activity, MSMS has a comparatively lean and efficient staff that helps to carry out that activity. MSMS membership dues go a long way in supporting MSMS activities.

Question: What services do physicians receive for payment of membership dues?

Doctor Baumann: One of the most important returns a physician receives on

this or her MSMS dues investment is a voice in organized medicine in Michigan, a voice in a powerful group representing 11,000 physicians in this state and a means for providing input on issues that affect physicians in their daily practices. Membership dues also provide access to such services as effective representation on legislative issues, to weekly and monthly news updates on organized medicine in *Medigram* and *Michigan Medicine*, and to special physicians' insurance plans.

Additionally, MSMS acts as a liaison for members on many fronts, interrelating with groups that affect how our profession carries out its work. For instance, MSMS fields physician problems with peer review organizations and works hard to ensure physician input on peer review standards. Earlier this year MSMS established an ombudsman program to expedite solutions to physician problems with Blue Cross Blue Shield of Michigan and Medicare. With a phone call to MSMS, physicians can have immediate access to help with benefits questions, reimbursement issues or just general problem-solving in this area.

MSMS exists to serve its members, and so membership dues provide them access

Continued on next page

State-by-State Association Dues Levels

	1989	1990		1989	1990
Washington, DC	660	685	Utah	340	340
Colorado	555	475	New York	325	325
Hawaii	530	520	North Carolina	325	325
Wisconsin	510	525	Kansas	320	320
Alaska	450	625	Wyoming	320	320
Pennsylvania	410	410	Nebraska	310	310
Arkansas	400	400	Connecticut	300	300
Kentucky	400	400	Florida	300	300
Minnesota	400	400	Massachusetts	300	300
Rhode Island	400	400	Missouri	300	300
Washington	398	418	Puerto Rico	300	290
Ohio	395	395	Virginia	300	300
Idaho	390	415	West Virginia	300	300
Arizona	375	375	Indiana	285	310
Maine	375	400	North Dakota	280	280
Oregon	375	375	Louisiana	270	300
California	370	410	Texas	265	265
Montana	370	370	Mississippi	260	285
Georgia	360	360	Alabama	250	250
Illinois	351	351	New Mexico	250	250
Iowa	350	350	Oklahoma	250	250
Michigan	350	350	Nevada	240	240
New Hampshire	350	375	Delaware	225	255
New Jersey	350	350	Maryland	225	255
South Dakota	350	350	South Carolina	220	254
Vermont	350	400	Tennessee	220	255

1990 Compositd Dues Survey/Preliminary Results/AMA

Continued from previous page

to representation and service. A situation which demonstrates MSMS effectiveness occurred when an MSMS member was informed one day by his hospital that he could not perform surgery the next day on a patient because he had unwittingly allowed his license to expire. The member contacted MSMS for help. MSMS worked quickly and efficiently, drawing on its government contacts to immediately renew the physician's license. The physician, with his license renewed, was able to perform surgery on his patient the next day. This is a rare and unusual situation, but it illustrates how MSMS membership dues provide members with top-notch representation and services.

Question: How does MSMS compare to other professions in the dues that it charges its members?

Doctor Baumann: With the 1991 fixed dues increase to \$440 each year for the next three years, MSMS ranks second in comparison to six other professions in what it charges its members for annual dues. (See chart below.) These professions include dentists, chiropractors, osteopaths, lawyers, nurses, and pharmacists.

Question: Will membership dues increase again, and, if so, when?

Doctor Baumann: My goal as MSMS treasurer is to stabilize membership dues, and I am always seeking alternatives to raising dues that will make that goal a reality. MSMS raises membership dues only when absolutely necessary to support functions our members demand. Early last year, the MSMS Finance Committee



"My goal as MSMS treasurer is to stabilize membership dues, and I am always seeking alternatives to raising dues that will make that goal a reality," says Billy Ben Baumann, MD, pictured above. "MSMS raises membership dues only when absolutely necessary to support functions our members demand."

and the Ways and Means Committee used a system of forecasting expenses and dues for a three-year period to determine what dues level would best support the MSMS priorities of organized medicine as framed by the House of Delegates. The Ways and Means Committee then submitted its recommendations on a dues increase to the MSMS House of Delegates, the representative body of the general membership which governs and sets MSMS policy. The House of Delegates is understandably reluctant to raise dues and does so only after careful deliberation as to the import and necessity of any increase.

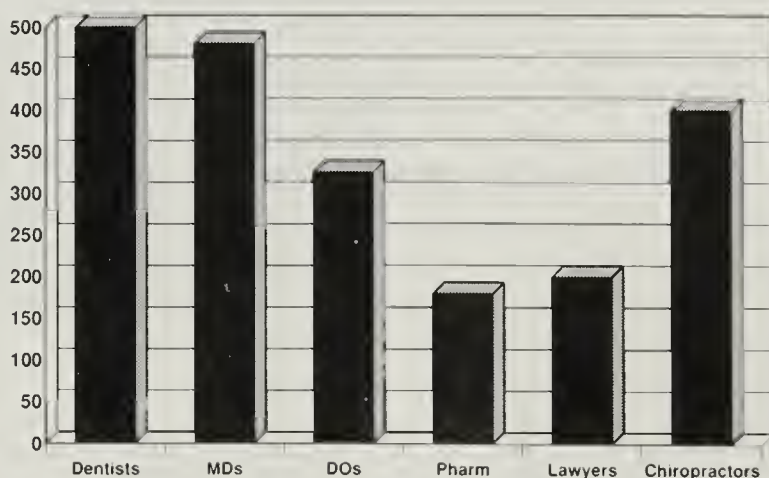
Prior to 1990, dues remained stable at \$260 between 1981-1984. They were raised \$30 to \$290 during 1985-1987, and then again another \$60 to \$350 between 1988-1990. The \$90 dues increase for 1991-1993 will bring membership dues to a total of \$440 each year during that cycle. Although I can't say now whether a dues increase will occur again in 1993, I can say that the issue is carefully decided only after much evaluation and deliberation about its necessity, and that we will make strenuous efforts to delay an increase as long as possible. Everything possible is being cut out of the MSMS budget so that we can tightly focus our financial resources on what our profession wants and needs to accomplish in the coming months.

Question: What is the current financial health of MSMS?

Doctor Baumann: MSMS is a financially strong organization. As I mentioned earlier, an important factor in providing solid representation for MSMS members is maintaining a solid financial core. One of the ways in which this core is maintained is by establishing and maintaining a strong membership base.

However, because it is difficult to meet the growing plethora of challenges to organized medicine on membership dues alone, MSMS has carefully invested its reserves in unique opportunities that will strengthen its financial core. For instance, with the growth of MSMS' originated company Michigan Physicians Mutual Liability Company (MPMLC), MSMS has established a joint venture corporation

Dues for Other Michigan Professionals



called Hagadorn, Inc. Under this joint venture, a new building is being constructed near MSMS headquarters that will allow MPMLC the physical space to expand its operation. The new structure has 89,000 square feet of building space, 60,000 square feet of which is already leased to MPMLC. Not only will this significantly increased space allow for MPMLC expansion, but it is being leased at a lesser cost per square foot than the space the company currently occupies. The remaining 29,000 square feet of space is leased to outside tenants and will begin to pay for itself soon after the building's completion. Hagadorn, Inc. will provide a continuous source of non-dues income for years to come.

Question: How many Michigan physicians are members of MSMS?

Doctor Baumann: MSMS currently represents 11,000 Michigan physicians out of the more than 14,500 practicing MDs in the state. That means our membership roster constitutes nearly 80 percent of all practicing MDs in Michigan. However, that still leaves about 3,500 physicians who are not MSMS members. Our goal is to increase our membership to 100 percent representation, in part because a larger membership base will strengthen MSMS as a whole, and in part because non-member physicians benefit at no cost from the gains that MSMS makes for all Michigan physicians.

MSMS is on the front lines for the medical profession, in the development of professional liability reform, in overseeing changes in the physician licensure system, in lobbying on federal and state legislation, and in protecting the medical profession from encroachment by nonprofessionals and paraprofessionals. MSMS also is on the front lines in educating physicians on medical ethics, risk management, and practice management.

Of the 11,000 members in MSMS, 600 physicians are directly involved in MSMS activities through its Board of Directors, House of Delegates, and 35 committees. A preliminary survey of the 34 Board members indicated that they spend about six hours per member per week in volunteer time to perform MSMS activities.

Although MSMS dues are important in maintaining a financial base for use in representing its members, physician input in MSMS activities is of extreme importance. Member physicians and their needs ultimately determine how MSMS resources are used. ■

Claudia Skutar is communications specialist for MSMS.

A message from the MSMS AUXILIARY

Dear Doctor:

As a member of your county and state society, you realize the importance of being an integral part of organized medicine in today's changing medical climate. With the intervention of numerous outside forces into your practice, the physician's role in our communities is no longer the same. MSMS and the MSMS Auxiliary work together to help the public understand what we have always known, that the patients' needs are the priority.

The MSMS Auxiliary is also changing. No longer is the Auxiliary primarily a social organization for physicians' spouses. True, the Auxiliary sponsors social activities for fellowship and serves as a support group for physicians' spouses and families; however, the Auxiliary is also involved in many different activities. Auxilians are actively working with and for MSMS in the legislative arena, sponsoring health-related programs (on drug abuse, teenage pregnancy, alcoholism, AIDS, health and nutrition), fundraising for medical education, and numerous other health-related projects.

One of the important efforts of the Auxiliary in recent years is the video on medical liability entitled, "Medicine in Jeopardy." This video is being promoted actively in all parts of the state to non-medical audiences by Auxiliary members. This project is only one of many Auxiliary activities which promotes a positive image of physicians in the local community.

The MSMS Auxiliary needs to make physicians aware of all the Auxiliary does and can do to help improve their images in the community. The Auxiliary needs physicians to encourage their spouses to join us in our efforts. If every spouse were involved and could donate a small segment of his/her time to even one project, our numbers would be unbeatable. The Auxiliary could accomplish so much more. Please discuss the importance of Auxiliary membership with your spouse. The MSMS Auxiliary needs and welcomes them. Help us show Michigan that Doctors' spouses care! ■

Lois Duhamel is membership chairman, MSMS Auxiliary. For more information on the MSMS Auxiliary, contact: Lois G. Duhamel, MSMSA membership chairman, c/o Vi Heins, P.O. Box 950, East Lansing, MI 48826-0950, (517) 336-7570.

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MSMS

COMMITTEES

address many issues

The 46 MSMS committees and task forces provide a platform for addressing issues ranging from aging to chemical dependency. To effectively address such a wide range of issues, MSMS committees rely heavily upon member input. MSMS encourages involvement of as many different physicians as possible from every geographical area.

Committee appointments are awarded annually at the MSMS Mid-summer Board of Directors Meeting held in July. Members are selected from a pool of applicants who have been nominated by current committee members, MSMS section officers and specialty and component society leaders. Committee appointments are for two-year terms, with new appointments taking place annually.

The first step toward obtaining a position, and the most difficult, is determining which committee (or committees) interests you most. A complete list of MSMS committees and task forces begins on this page. Each committee listing includes a brief statement of goals.

Members interested in serving on a committee must be appointed by the MSMS Board of Directors. Simply contact a current committee member, MSMS section leader, MSMS Board member, your county medical society or specialty society, or contact MSMS headquarters and request a recommendation. Each January MSMS begins seeking recommendations for committee appointments for the coming year. So now is a good time to start thinking about what committee you would like to join.

For more information on any of the MSMS committees, contact Jeanne Miller at MSMS.

Committee on Aging

This Committee provides physicians with an overview of the medical, social and psychological needs of the aged patient. Activities include examining the health status of the older patient, advocating preventative medicine programs, discussing Medicare financing, and exploring long-term care options for the elderly. The Committee works with many community organizations and the State Office of Services for the Aging.

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John Peterson, PhD, Consultant, Lansing
James R. Tarrant, Consultant, Lansing
F. B. "Tom" Plasman, Staff

Committee on MSMS Archives

This Committee researches and retains a record of Michigan medical history so it will be preserved for future generations.

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Troy
Chairman

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Continued on page 23



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Ahmad



Aiken



Allaben



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180-mg Calan SR...once-daily, single-agent therapy

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‡Price comparison versus 240-mg Calan SR.

Please see next page of this advertisement for references and a brief summary of prescribing information.

SEARLE

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References:

1. Data on file, G.D. Searle & Co. 2. 1988 Joint National Committee: The 1988 report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 1988;148:1023-1038.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol clearance may occur with combined use. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration.

Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, increased urination, spotty menstruation, impotence.

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Task Force on AIDS Education

This Task Force develops strategies for educating physicians about AIDS and coordinates MSMS efforts in physician and public education with those of the Michigan Department of Public Health.

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Liaison Committee With Michigan Medical Arbitration System

This Committee serves as a liaison between MSMS and the Michigan Medical Arbitration System and works to promote the use of arbitration in Michigan.

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Committee on Awards

This Committee supervises the MSMS award program and makes recommendations to the Board of Directors.

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Thomas C. Payne, MD, East Lansing
Katie Brewbaker, Staff

Committee on Bioethics

This Committee considers questions about scientific, medical, moral, ethical and political concerns dealing with the beginning of life and the ending of life which have raised increasing problems for physicians and, therefore, MSMS.

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William B. Weil, MD, East Lansing
Peter A. Levine, Consultant, Flint
Katie Brewbaker, Staff

Liaison Committee With Blue Cross Blue Shield of Michigan

This Liaison Committee serves as a communication link to assist individual physicians in obtaining information concerning Blue Cross Blue Shield of Michigan's policies and procedures, and provides input to aid in the resolution of problems which may arise. The Committee also considers and provides input on major policy and professional issues related to BCBSM.

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Committee on Communications and Professional Relations

This Committee develops and oversees all public relations and public service activities. It provides physician input to the program suggestions and activities advanced by outside consultants and MSMS staff.

Henry M. Domzalski, MD

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D. V. Ramana, MD, Davison
M. Gary Robertson, MD, Grand Haven
Jerry H. Rosenberg, MD, Southfield
Judy Marr, Staff

Committee on Constitution and Bylaws

This Standing Committee reviews proposals to amend the MSMS Constitution and Bylaws and presents recommendations for appropriate action by the MSMS House of Delegates. It serves as a reference committee during the House of Delegates meeting.

Robert H. Evans, MD

*Sturgis
Chairman*

Robert D. Allaben, MD, Detroit
N. Warn Courtney, MD, Kalamazoo
Angel Farina, MD, Garden City

Continued on page 24



Barry



Baumann



Bluhm



Brody



Bryant

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 Dorothy M. Kahkonen, MD, Detroit
 William E. Madigan, ex officio, East Lansing
 Steven E. Newman, MD, Southfield
 Richard D. Weber, Consultant, Detroit
Vada L. Davis, Staff

Committee on CME Accreditation

This Committee assures that quality CME activities are available to Michigan physicians through review, evaluation, and accreditation of Category I continuing medical education providers in the state.

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 Thomas J. DeKornfeld, MD, Consultant, Lansing
Vada L. Davis, Staff

Committee on CME Programming

This Committee develops, conducts, and supervises Category I programs in Michigan to serve the continuing medical education needs and interest of physicians. It also is empowered to jointly sponsor programs which meet the CME criteria for Category I.

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 Joan C. Stryker, MD, Detroit
 James R. Tarrant, Consultant, East Lansing
Sherry L. Fent, Staff

Advisory Committee on Health Care Policy

This Committee recommends MSMS policy on health planning. It encourages physician involvement in state health planning activities and in state health policy activities.

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Steering Committee on Program to Assist Impaired Physicians

This Steering Committee provides assistance, through its medical director and a statewide network of volunteer physicians, to physicians who have problems related to emotional illness, alcoholism, chemical dependency, and physician impairment, and serves as the advisory body to the Physicians Recovery Network. Education and research toward prevention, case finding, and intervention are major components of the program.

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 Gerald A. Vander Voord, MD, East Lansing
 Michael L. Zarr, MD, Flint
 Richard D. Weber, Consultant, Detroit
Katie Brewbaker, Staff

Committee on Maternal and Perinatal Health

This Committee strives to improve the care of the obstetrical patient and her newborn and to provide means for physicians, nurses, and others interested in maternal, perinatal, and neonatal health to discuss mutual problems and share ideas. It works in close cooperation with the state agencies and medical specialty organizations.

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Continued on page 25



Domzalski



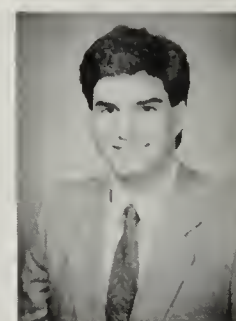
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Vada L. Davis, Staff

Advisory Committee to Section on Medical Economics

This Advisory Committee assists MSMS in setting priorities, studies current health care financing, makes specific recommendations concerning future financing mechanisms, and develops an understanding of traditional insurance companies, emerging alternative financing and health delivery systems.

Gilbert B. Bluhm, MD
Southfield
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Task Force on Rural Health Care

The Task Force gathers information on the increasing challenges of change occurring in rural health care and helps physicians make the necessary practice changes so that they may continue to provide quality health care to rural Michigan residents.

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Liaison Committee with Michigan Peer Review Organization (MPRO)

This Liaison Committee monitors the activities of the federal peer review organization in Michigan (MPRO), provides policy input to MPRO on medical and operational issues, meets with MPRO representatives to discuss matters of mutual interest, and assists individual physicians in dealing with problems or concerns they may have with MPRO.

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Advisory Committee on Office Automation

This Committee advises staff in its plan for automation of MSMS office operations.

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 Fred E. Patterson, MD, Jackson
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Vada L. Davis, Staff

Planning Committee for Michigan Conference on Maternal and Perinatal Health

This Planning Committee plans and implements the Category 1 CME program for the annual Michigan Conference on Maternal and Perinatal Health, in cooperation with several other participating organizations.

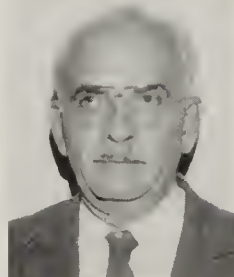
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Planning Committee for MSMS Annual Scientific Meeting

This Planning Committee, under the guidance of the Committee on CME Programming, plans and presents Category I Credit courses at the Annual Scientific Meeting. It provides CME courses of value to all specialties while striving to improve methods of education and evaluation.

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Committee on MSMS Policy

This Committee reviews actions of the House of Delegates and incorporates any policy decisions into the Policy Manual of MSMS.

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Hagadorn, Inc.

Hagadorn, Inc. was formed in 1987 and is a joint venture between the Michigan State Medical Society and the Michigan Physician's Mutual Liability Company. It expects to generate non-dues income for MSMS, and its first project is to build an 87,000-square-foot office building in East Lansing. The major tenant in the building will be Michigan Physician's Mutual Liability Company.

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Task Force on Professional Liability

This Task Force reviews the professional liability

climate in Michigan and the nation, is familiar with proposed reforms, and recommends appropriate legislative or other improvements.

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Medicaid Liaison Committee

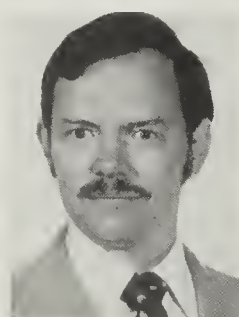
This Liaison Committee attempts to resolve individual physicians' problems with Medicaid payments and procedures, and discusses major policy issues of the Medicaid program with state government.

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Committee on Medical Licensure and Discipline

This Committee serves as a liaison to the Michigan Department of Licensing and Regulations and the Michigan Board of Medicine, and seeks and supports measures that will promote a fully effective Board of Medicine.

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This Committee guides all recruitment efforts aimed at non-member physicians, residents, and students. It develops membership goals, makes recommendations to the Board of Directors and conducts personal recruiting efforts when needed.

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Daniel R. Farhat, Staff

Committee on Federal Legislation

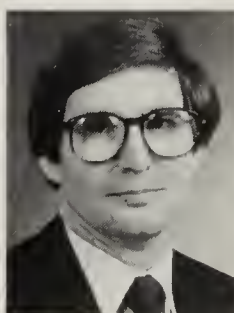
This Committee monitors and influences federal legislation, and rules and regulations in conjunction with the AMA Washington office.

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This Committee provides for regular communication between MSMS and the members of specialty organizations. It deals with any subject of mutual concern except scientific or clinical medicine.

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David Fox, Staff

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This formal Liaison Committee is composed of designated leaders of the two organizations. The Liaison Committee does not make policy for either organization; each organization refers any recommendations to the MSMS Board of Directors or MHA Board of Trustees for approval.

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Marguerite R. Shearer, MD, Ann Arbor
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Committee on Sports Medicine

This Committee develops and presents a conference aimed at physicians and others with an interest in sports medicine. It also provides sports medicine information and medical evaluation of sports rules when requested by the Michigan High School Athletic Association, Inc.

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Russell Miller, Consultant, Ann Arbor
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Alexa Canady, MD, Detroit
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Robert E. Paxton, MD, Fremont
Richard D. Weber, MD, Detroit
Kevin Kelly, Staff

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This Committee monitors and influences Michigan legislation through the legislative process, and monitors and responds to Michigan government rules and regulations as they are promulgated.

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Dennis Muchmore, Consultant, Lansing
Richard D. Weber, Consultant, Detroit
Daniel R. Farhat, Staff

Task Force on Health Care for the Uninsured

This Task Force reviews legislative and administrative proposals relative to health care for the uninsured and analyzes their impact on physicians, facilitates the involvement of MSMS and its members in pilot projects or volunteer efforts, and formally interacts with other organizations addressing the problem of health care for the uninsured, including the Governor's Task Force on Health Care for the Uninsured.

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Ann Arbor
Chairman

Robert A. Bitterman, MD, Ann Arbor
Michael C. Boucree, MD, Flint
Deloisteen Brown, MD, Ypsilanti
John J. Collins, Jr., MD, Farmington Hills
H. Richard Henderson, MD, Farmington Hills
Samuel D. Indenbaum, MD, Birmingham
Robert P. Lorenz, MD, Royal Oak
Jack M. Stack, MD, Alma
Charles A. Thompson, MD, Flint
Richard M. Tooker, MD, Kalamazoo
Robert M. Weber, MD, Flushing
Warren C. White, Jr., Consultant, Lansing
Mary Anne Ford, Staff

Committee on Ways and Means

This Committee furnishes cost estimates to the House of Delegates on resolutions requiring new expenditures of funds. It also reviews general fiscal policies of the Society and makes recommendations regarding member dues.

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Detroit
Chairman

Billy Ben Baumann, MD, Pontiac
Warren E. Bontrager, MD, Mio
Arnold L. Brown, MD, Union Lake
Richard P. Heuschele, MD, Saginaw
David M. C. Hislop, MD, Port Huron
Earl G. Moehn, MD, Mt. Clemens
Robert C. Prophater, MD, Bay City
James K. Watkins, MD, Grand Rapids
B. David Wilson, MD, Kalamazoo
Richard M. Campau, Staff

Committee on Concerns of Women Physicians

This Committee explores ways to encourage the participation and leadership involvement of women physicians in organized medicine.

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Ann Arbor
Chairman

Tama D. Abel, MD, Ann Arbor
Miriam S. Daly, MD, Albion
Fereshteh Fahimi, MD, Lansing
Julia A. Hardy, MD, Ann Arbor
Cassandra M. Klyman, MD, Bloomfield Hills

Vivian M. Lewis, MD, Flint
 Linda J. Logsdon, MD, Franklin
 Judith L. Meyer, MD, Grandville
 Janet R. Osuch, MD, East Lansing
 Sarla Puri, MD, Grand Rapids
 Diana M. Rothman, MD, Ypsilanti
 Marguerite R. Shearer, MD, Ann Arbor
 Dawn E. Springer, MD, Mason
 Janice L. Werbinski, MD, Portage
Deborah Zannoth, Staff

Task Force on Environment and Health

This Committee educates physicians, the public and state government regulators about the effects of the environment on human health; to develop MSMS policy on environmental issues; and to identify MSMS members with interest and expertise in environmental issues and the human health effects of environmental hazards.

Susan H. Adelman, MD
Southfield
Chairman

Thomas J. Archambeau, MD, Lansing
 Regine Aronow, MD, Detroit
 B. Douglas Campbell, MD, Battle Creek
 Martin L. Charles, MD, Livonia
 John C. Crockett, MD, Lansing

Howard J. Dworkin, MD, Royal Oak
 Carl M. Frye, MD, Ann Arbor
 Alan G. Kaplan, MD, Birmingham
 Thomas E. Lipps, MD, Midland
 Linda J. Logsdon, MD, Franklin
 Frederick E. Ludwig, MD, Port Huron
 Robert A. Margulies, MD, Saginaw
 John R. Petraskey, MD, Menominee
 Maurice S. Reizen, MD, Okemos
 Earl S. Rhind, MD, Holland
 William N. Richardson, MD, Warren
 Kenneth E. Rowe, MD, Hancock
 Dean G. Sienko, MD, DeWitt
 Robert M. Soderstrom, MD, Flint
 Alfred B. Swanson, MD, Grand Rapids
 Stanley B. Wolfe, MD, Bloomfield Hills
Mary Anne Ford, Staff

Focus Group on Chemical Dependency

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Southfield
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 Brooks F. Bock, MD, Detroit
 LaClaire G. Bouknight, MD, Lansing
 Sharonlee Burmeister, Perry
 Beverly Chisholm, MSW, Detroit
 Paul D. Croissant, MD, Bloomfield Hills
 Pat Dolan, Kalamazoo

Carol Franck, RN, East Lansing
 Dave Fukazawa, Detroit
 Jerome Gallagher, PhD, Mason
 Charles F. Gehrke, MD, Ypsilanti
 Rosalind E. Griffin, MD, Southfield
 Thomas L. Haynes, MD, Grand Rapids
 Cecelia Hissong, MD, Dearborn Heights
 James K. Johnson, MD, Detroit
 Cecil R. Jonas, MD, Southfield
 Bobbe J. Kelly, DO, West Bloomfield
 D'Anne M. Kleinsmith, MD, W. Bloomfield
 Douglas W. MacDonald, MD, Oxford
 Douglas A. Mack, MD, Grand Rapids
 Philip M. Margolis, MD, Ann Arbor
 Robert Niccolini, MD, Detroit
 Robert Niven, MD, Southfield
 Enrique M. Ostrea, MD, Detroit
 Delbert E. Pearson, MD, Ann Arbor
 Susie Pederson, Bay City
 Rhoda M. Powsner, MD, Dearborn
 Mike Reagan, Grand Rapids
 Thomas Renkes, East Lansing
 Krishna K. Sawhney, MD, Farmington Hills
 Joan C. Stryker, MD, Detroit
 Lionel F. Swan, MD, Detroit
 Gerald A. Vander Voord, MD, East Lansing
 Joan Walker, Lansing
 James N. Wardell, MD, Detroit
 Paul E. Williamson, Southfield
Katie Brewbaker, Staff

Component medical societies are closely tied to MSMS

Every component medical society is represented on the MSMS Board of Directors by one or more elected physicians, depending on the size of that group's membership. In addition, an MSMS staff member is assigned as liaison and resource person to each component society. The contact persons are indicated below.

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 B. David Wilson, MD
 Staff: Tom Plasman

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 Staff: Richard Campau

Arenac-Iosco Counties
 Director: James L. Fenton, MD
 Staff: Vada Davis

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 Willard S. Stawski, MD
 Staff: Katie Brewbaker

Bay County
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 Staff: Vada Davis

Berrien County
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 B. David Wilson, MD
 Staff: Debbie Zannoth

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 Staff: Rose Heald/Julie Lester

Calhoun County
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 Staff: Rose Heald

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 Staff: Tom Plasman

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 Staff: David Fox

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 Staff: Judy Marr/Claudia Skutar

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 Staff: David Fox

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County medical society membership There are many benefits

By Peter Levine

If you've been wondering, what has my county medical society done for me lately, take a moment to contact your county society executive director and find out. That's what one Genesee County physician did, and he found out plenty. The following is an account written by Peter A. Levine, MPH, executive director of the Genesee County Medical Society. The article first appeared in the June issue of *The Bulletin*, the Genesee County Medical Society's monthly newsletter.

MSMS called recently regarding a long-time member who wished to drop his Genesee County Medical Society membership. I have known him for years and got on the telephone to find out what was wrong. He stated that he could not identify any GCMS activity which benefited him. The conversation took place during an intense week of GCMS activity on behalf of its members. I felt compelled to launch into a description of the crisis related activities, alone, that involved members and what the GCMS's intervention strategies were for each of them. The activities for that particular week included:

■ *The Blue Cross Contract:* Active daily review of and comments on the Blue Cross Blue Shield of Michigan Provider Contract to MSMS regarding GCMS physicians' opinions of each line and word of each draft of the new BCBSM physician contract. That input in conjunction with the expert negotiation methods exercised by MSMS resulted in remarkable changes to the contract, making it a much better document than it had been in the first draft.

■ *HCAP:* The Medical Society was simultaneously involved in actively working to save the Health Care Access Project and the Physician Sponsor Plan, which provides access to care for General Assistance and other historically uninsured patients by increasing physician reimbursement in Genesee and Marquette Counties only, and drastically reducing the pa-

perwork required by physicians to take care of those patients.

■ *Medicare Bill:* The Medical Society worked intensively to achieve Congressional support of House Bill 4475, which would change the punitive components of the Medicare program and make participation in the Medicare program more tolerable.

■ *Mandatory Medicare Assignment:* The GCMS played a critical role in developing opposition to Mandatory Assignment legislation for the Medicare program in Michigan.

■ *Limited Liability Legislation:* The GCMS identified a member to provide testimony in Lansing in support of a limited liability bill for physicians involved in emergency room cases.

■ *Influence on MSMS Policy:* Final submission of resolutions to the MSMS House of Delegates was completed during that week.

■ *Outside Oversight of Continuity of Care:* The GCMS pursued an aggressive stand vis-a-vis a local organization which was endeavoring to circumvent a community-wide coalition on AIDS which deals with the issue of continuity of care.

■ *Peer Review:* The Mediation Subcommittee met for several hours, utilizing the voluntary time of 15 physicians, as well as staff, to deal with peer review related issues.

■ *Media Relations:* In addition, the GCMS provided substantive input to several newspaper articles on a local basis, and distributed scores of copies of living wills around the State. This promotes the GCMS and its membership as patient oriented, and provides the public with important health information.

■ *AIDS Task Force:* The GCMS convened the AIDS Task Force; a consortium of organizations from the community-at-large, as well as physicians and hospital representatives designed to develop prevention and continuity of care guidelines.

■ *Community Health:* The Community Health Committee was convened. This is a committee designed to provide physician input to community organizations on an as requested basis.

■ *The Bulletin:* The content for (the June) issue of *The Bulletin* (the GCMS newsletter), was assembled.

■ *Seminars Held:* A Media Relations

Seminar was held in conjunction with MSMS in Flint to allow physicians to develop media communications skills, to better promote medicine to the public.

■ *A Seminar on Billing Practices* was produced in conjunction with the Ruybar Group and the Tri-Med Group. This was attended by well over 100 physicians, office managers, and billing clerks from physicians' offices.

■ *Physician Reimbursement Other Than BCBSM Contact:* During this week, staff endeavored, along with a Blue Cross Physician Board member, to identify where three physicians were in the Blue Cross audit and appeals process. Those interventions resulted in significant amounts of information being submitted to the member physicians, and a satisfactory conclusion in two of the three cases.

These are the primary activities that went on during the week that this physician happened to decide that our activity level was not sufficient. The list of activities does not even include the activities of (two GCMS staff members) who keep the office running, the records intact, the correspondence written, appointments from conflicting, committee meetings rolling, physicians' records organized, bills paid, and yours truly mollified.

It is impossible to document the number of hours that physicians and staff spend on physician advocacy, as well as public health advocacy. There is, however, a tremendous need for increased involvement on the part of the physician membership. There will never be enough involvement of the membership, because there will never be a cessation of the efforts by third party payors, government oversight task forces, and government agencies, to make the practice of medicine less palatable, and patient access to care tougher to achieve. It is incumbent upon GCMS to do as much as possible on behalf of its membership and the public, but without the involvement of its membership, it becomes a shell organization.

P.S. This poor member who listened to my description of the activity level of the Medical Society during the week of his phone call, did agree that we were worth the membership dues. ■

Peter Levine is executive director of the Genesee County Medical Society.

American Medical Association

What has it done for you lately?

By Robert D. Burton, MD
and Frank B. Walker, MD



MSMS Immediate Past-President Robert E. Paxton, MD, then MSMS president (left), receives the American Medical Association 1989 Membership Award on behalf of MSMS from Alan R. Nelson, MD, then AMA president, during the AMA Leadership Conference held last February in Phoenix, Arizona. MSMS received the award for having more AMA members than the year before.

One frequently hears a physician make the statement, "Why should I join the American Medical Association, it has done nothing for me." No statement reflects more conclusively the lack of understanding or interest in the AMA's role. The AMA has played a significant role in our professional lives from the day we entered medical school, by its participation in setting the high standards of both the medical schools we graduated from and the residency training programs we experienced. That AMA also has been deeply involved with specialty organizations in establishing specialty boards, as well as requirements for certification in a physician's specialty.

The AMA is involved in the study and evaluation of all aspects of medical education and continuing medical education. Programs approved by the House of Delegates are being developed to ensure the provision of a continuing supply of well-qualified physicians to meet the medical needs of the public.

The AMA reviews the changing socioeconomic aspects of medical care, and on behalf of the public and the profession, suggests methods for the timely and equitable development of services. It confers with state constituent medical associations, component societies and national medical specialty societies regarding the

status of anticipated proposals that affect medical care. Moreover, the AMA has been a compelling force in the continuous battle against overwhelming odds to preserve our free enterprise, pluralistic health care system. This has, without a doubt, ensured Americans the highest quality health and medical care in the world!

Organized medicine needs our support

Organized medicine needs our membership, participation and involvement. Today, less than 50 percent of practicing physicians belong to the AMA. We should be 100 percent strong.

The AMA is the only organization capable of representing the entire spectrum of medicine at the national level. Its House of Delegates represents all 50 states, and more than 70 specialty organizations, hospital medical staffs, medical schools, resident physicians and medical students and physicians in the military service. The AMA House of Delegates is a democratic group made up of physicians with philosophical leanings ranging from ultra conservative to extremely liberal.

All issues brought before the House of Delegates are debated before reference committees and any member of the AMA may appear before a committee to give his

or her views and make recommendations on any issue. The reference committee submits its recommendations to the AMA House of Delegates and the issues may be debated again, before the House prior to the vote.

America needs a strong national voice

At this time of increasing federal legislation and regulatory pressure, American medicine needs a strong national voice. The question becomes not whether you can afford to join but why do you not belong? It's really your professional obligation to join and to work to preserve the quality medical care that your predecessors in the profession worked to develop and have passed on to you. Alone we cannot exert much influence, but collective and cohesive strength can make a difference. Help us bring in new members who will make us stronger, our voices more effective, aid us in surmounting our current obstacles, and tie us together in an unbreakable bundle. ■

Doctor Burton, a Grand Rapids otorhinolaryngologist, is chairman of the MSMS Delegation to the AMA and is MSMS president-elect. Doctor Walker, a Detroit pathologist, is a member of the AMA Board of Trustees.

American Medical Association (AMA)

HOW IT WORKS



House of Delegates

436 Total Delegates

398 State Delegates

12 Delegates from Michigan

RATIO: 1 Delegate/1000 Members

78 Specialty Delegates

- Meets twice a year (June & December)
- Overall policy-making body
- Elects Officers
- Elects Trustees
- Elects Council Members
- Receives and acts on reports from Trustees, Councils and 9 reference committees

10 Branches of Federal Services, Medical Schools, Medical Students, Resident Physicians, Young Physicians and HMSS

AMA Sections

Medical Student Section
Resident Physician Section
Hospital Medical Staff Section
Young Physicians Section
Medical School Section

Board of Trustees

President

President-elect

Immediate Past President

12 Elected Board Members

1 Resident Physician Member

1 Medical Student Member

- Meets throughout the year
- Policy-making body between meetings of the House of Delegates
- Reports back to the House of Delegates

AMA Departments

- Senior Management
- Office of General Counsel
- Financial Services and Real Estate
- Medical Education & Science
- Medical Education
- Science & Technology
- Scientific Information
- Public Affairs
- Health Policy
- Professional Relations
- Marketing, Membership & Strategic Planning
- Human Resources
- Administrative Services
- Publishing

AMA Council

- Construction and Bylaws
- Medical Education
- Long Range Planning and Development
- Scientific Affairs
- Legislation
- Ethical and Judicial Affairs
- Medical Service

Michigan Physicians Holding Positions in AMA

John J. Coury, MD (Port Huron), Past President

Frank B. Walker, MD (Grosse Pointe), Board of Trustees

Richard J. McMurray, MD (Flint), Council on Ethical & Judicial Affairs

Donald K. Crandall, MD (Muskegon), Council on Medical Service

Robert D. Burton, MD (Grand Rapids), Chair of the Michigan Delegation to the AMA

A. Bradley Eisenbrey, MD (Grosse Pointe Woods), Council on Scientific & Educational Affairs

Busharat Ahmad, MD (Marquette), Chair, Advisory Committee on International Medical Graduates

Susan Hershberg Adelman, MD (Southfield), AMA Women in Medicine Advisory Panel

George W. Slagle, MD (Battle Creek), Past Vice President

Michigan State Medical Society (MSMS)

HOW IT WORKS



House of Delegates

- 280 Total Delegates
- 239 County Delegates
- RATIO: 1 Delegate/50 Members
- 1 Hospital Medical Staff Section
- 1 Young Physicians Section Delegate
- 1 Graduate Foreign Medical Schools
- 3 Medical Student Delegates
- 1 Resident Physician Delegate
- 34 Specialty Society Delegates
 - Meets once a year (April/May)
 - Elects Officers
 - Elects Directors
 - Elects AMA Delegates/Alternate Delegates
 - Receives and acts on reports from directors, committees and 8 reference committees

MSMS Sections

- Medical Student Section
- Resident Physician Section
- Hospital Medical Staff Section
- Young Physician Section
- Graduates of Foreign Medical Schools

Reference Committees

- Committee A - Medical Care Delivery
- Committee B - Legislation
- Committee C - Internal Affairs & Public Service
- Committee D - Professional Liability
- Committee E - Public Health & Miscellaneous
- Committee F - Medical Education & Misc.
- Committee on Constitution & Bylaws
- Committee on Ways and Means

Board of Directors

- 8 Officers
- Chair
- Vice Chair
- 26 District Directors
 - Meets throughout the year
 - Policy-making body between meetings of the House of Delegates
 - Acts upon reports from the officers and committees

MSMS Committees

- Aging
- Archives
- Awards
- Bioethics
- Liaison Committee with Michigan Medical Arbitration System
- Liaison Committee with BCBSM
- Committee to Review Insurance Programs
- Advisory Committee on Communications and Professional Relations
- Awards
- CME Accreditation
- CME Programming
- Liaison Cmt. with Corporate Medical Directors
- Advisory Committee on Health Care Policy
- Program to Assist Impaired Physicians
- Maternal and Perinatal Health
- Advisory Cmt. to Section on Medical Economics
- Medicaid Liaison Committee
- Medical Licensure & Discipline
- Membership Recruitment & Retention
- Liaison Committee with MDPH
- Liaison Committee with MMAS
- Liaison Committee with MPRO
- Liaison Committee with State Bar
- Scientific Mtg. & Maternal Health Conference Cmts.
- Sports Medicine
- State Legislation & Regulation
- Concerns of Women Physicians
- Committee on Constitution & Bylaws
- Committee on Policy Manual
- Task Force Committees on the following: AIDS Education, Professional Liability, Public Affairs Leadership Conference, Rural Health
- Environmental Health, Chemical Dependency

WHOM TO CALL AT MSMS HEADQUARTERS

EXECUTIVE DIRECTOR: WILLIAM E. MADIGAN

ASSISTANT DIRECTOR: KEVIN A. KELLY

(517) 337-1351

The individuals listed at right are a very integral part of the Michigan State Medical Society – they are the staff. The 65 members of the staff provide a wealth of information and assistance every day to MSMS members who have questions and want answers.

Here are just a few of the questions MSMS has received and answered: "Medicare has not sent a payment in three months and I have provided over \$60,000 worth of treatment. Who can I talk to at BCBSM about this problem?" "I neglected to renew my license and I am scheduled for surgery tomorrow. I cannot reach the Department of Licensing and Regulation. Can you help me?" Staff was able to provide assistance to these physicians and stands ready to assist the membership everyday.

Do not forget that the MSMS staff members listed at right can help you through a bureaucratic maze, give you the most complete information about the current health care delivery system, or simply provide you with directions to the MSMS building. If you have questions, we encourage you to pick up the phone and call us.



Address changes	Peg Berry
Advertising (in <i>Michigan Medicine</i>)	Betty McNerney
AIDS Provider Education Project	Lisa Strother
AMA Delegation	Judy Marr
Annual Scientific Meeting Program	Sherry Fent
Arbitration	Mary Anne Ford
Auto Lease Plan	Richard Campau
Blue Cross Blue Shield/Third Party Payors	Robert Ortwein
Board of Medicine	Dan Farhat, Tom Wolff
Continuing Medical Education	
Accreditation	Katie Brewbaker
Category I Calendar (in <i>Michigan Medicine</i>)	Sherry Fent
MSMS-Sponsored Conferences	Sherry Fent
Dues Billing & Payments	Peg Berry
Federal Legislation	Kevin Kelly
Financial Operations	Richard Campau
Graduate Medical Education	Sherry Fent
Group Health Insurance Plan	Barb Zimmerman, Valerie Barker
Health Data Research	Julie Lester
Health Education Foundation	Vada Davis
HMOs/PPOs	Robert Ortwein
Hospital Medical Staff Relations	Tom Plasman
Judicial Commission	Katie Brewbaker
Legislation	Dan Farhat, Tom Wolff
Maternal Health Conference	Sherry Fent
Media Relations	David Fox
Medicaid	Mary Anne Ford
Medical Assistants	Caroline Kimmel
Medical Ethics	Katie Brewbaker
Medicare	Robert Ortwein, Rose Heald
<i>Medigram</i>	Betty McNerney, Claudia Skutar
Member Benefits (including insurance programs)	Richard Campau
Membership Records	Peg Berry
Membership Recruitment	Deborah Zannoth
Michigan Allergy Society	Viola Heins
Michigan Association of Medical Education	Viola Heins
Michigan Dermatological Society	Dawn Reha
Michigan Doctors Political Action Committee	Kevin Kelly, Dan Farhat
Michigan Chapter, American College of Surgeons	Viola Heins
Michigan Medical Group Managers Association	Caroline Kimmel
<i>Michigan Medicine</i> (MSMS Journal)	Betty McNerney
Michigan Society of Anesthesiologists	Caroline Kimmel
Michigan Society of Internal Medicine	Caroline Kimmel
Michigan Society of General Surgeons	Caroline Kimmel
Michigan Society of Pathologists	Viola Heins
Michigan Society of Respiratory Therapy	Caroline Kimmel
MSMS Auxiliary	Viola Heins
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	Richard Campau, Donna Farougi
MSMS Meeting Facilities	Lori Randall
MSMS Travel Programs	Donna Farougi
Physicians Communication Network	Katie Brewbaker
Physicians Recovery Network	Katie Brewbaker
Peer Review Organization	
of Michigan, Inc. (PROM)	John Richards, Barbara Banks, RN
Physician Legislative Network	Dan Farhat, Tom Wolff
Physician Service Group, Inc.	John Richards
Seminars	Amy Fistler
Practice Management	John Richards, Amy Fistler
Professional Liability Insurance	Richard Campau
Public Health Liaison	Mary Anne Ford
Public Relations	Judy Marr
Risk Management	Richard Campau
Specialty Societies	Donna Farougi

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Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of non-susceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon.

Those reported include:

- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, serum-sickness-like reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy, occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.

- Stevens-Johnson syndrome, toxic epidermal necrolysis,

and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

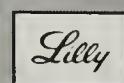
Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

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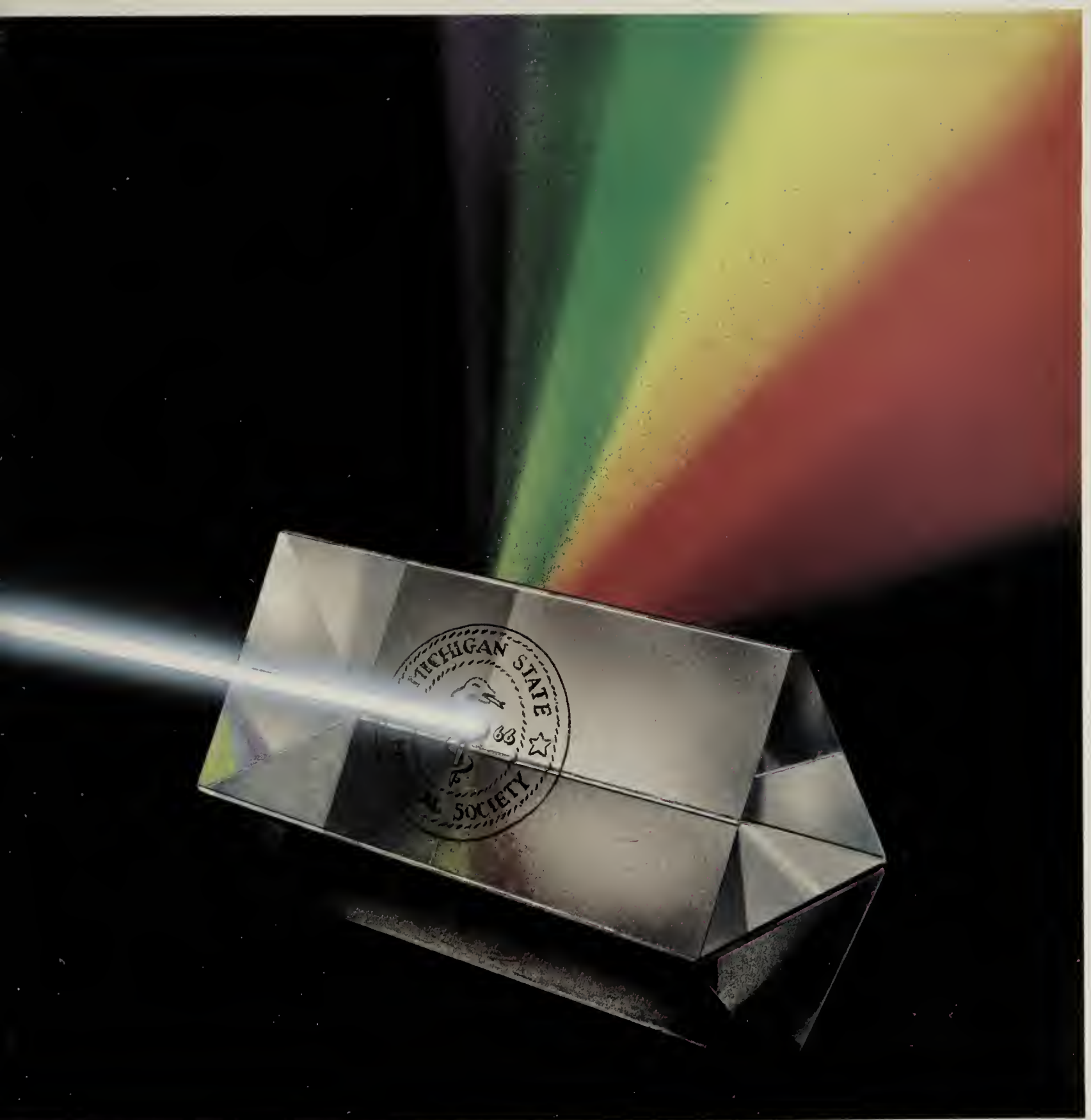
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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.



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Indianapolis, Indiana 46285

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Spectrum of Medicine in the 90's

Michigan State Medical Society
1990 Annual Scientific Meeting
November 6, 7, & 8
Hyatt Regency Dearborn



Welcome to the Meeting...

1990 MSMS Annual Scientific Meeting November 6, 7, & 8 Hyatt Regency Dearborn

Welcome to the 125th Annual Scientific Meeting of the Michigan State Medical Society.

We thank the many medical specialty societies, MSMS sections, hospitals and medical school departments which have planned courses and are cooperating in this comprehensive CME project.

Please fill in the evaluation forms for each course and the special CME questionnaire so MSMS will know how to better serve the CME needs of Michigan physicians and to further improve the Meeting next year.

We thank you for participating in this Scientific Meeting, which is truly one of the most outstanding presented by any state medical society.

Planning Committee for MSMS Annual Scientific Meeting

Conrad E. Nagle, MD, Troy, Chairman
Rudi Ansbacher, MD, Ann Arbor
Frederick W. Bryant, MD, Troy
Miriam Daly, MD, Albion
John E. Freitas, MD, Royal Oak
Alan B. Gruskin, MD, Detroit
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Nicholas J. Lekas, MD, Dearborn
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Roger M. Morrell, MD, Lathrup Village
John O'Donnell, MD, Grand Rapids
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Robert W. Rosenbaum, MD, Flint
Joan C. Stryker, MD, Detroit

David R. Rovner, MD, East Lansing, *Chairman*
MSMS Committee for CME Programming

Jack L. Barry, MD, *Chairman*
MSMS Board of Directors

Susan Hershberg Adelman, MD, Southfield
MSMS President

Life Support Station



IN CASE OF EMERGENCY...In the Hyatt Regency Dearborn, **CALL 1280**, Tuesday, November 6 from 8:00 a.m. to 6:00 p.m.; Wednesday, November 7, from 8:00 a.m. to 6:00 p.m.; Thursday, November 8, from 8:00 a.m. to 5:30 p.m. or go to the Life Support Station adjacent to the pool on the first level. **AT ALL OTHER TIMES CALL 2222** and state the emergency.

This MSMS Annual Scientific Meeting, in cooperation with the Michigan Chapter, American College of Emergency Physicians, is prepared to handle medical emergencies of all its participants that may occur within the physical confines of the Hyatt Regency Dearborn. The Life Support Station is staffed Tuesday through Thursday during the hours of the meeting by emergency medicine residents from area hospitals and by nurses and/or paramedics from the Lansing area. Please read carefully the following:

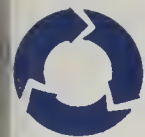
1. If an emergency (e.g., cardiac arrest) occurs during the hours the Station is open, proceed to the nearest telephone and **call 1280**. State the floor, area and room the patient is in and the nature of the problem as well as the number of the phone from which you are calling.
2. When the Life Support team arrives, they will assume command of the emergency care. Do not interfere or offer assistance unless asked to do so. Assist with crowd control and open a passageway for evacuation of the patient.
3. Do NOT summon an ambulance or call the hospital as this will be done by the team.
4. Persons needing medical attention may come directly to the Life Support Station.
5. Robert K. Orr, Jr., DO, is the director of the Life Support Station. Inquiries concerning Life Support Station operation should be directed to him.

MSMS Thanks the following for contribution of equipment and supplies to the Life Support Station:

Lansing Mercy Ambulance Service

St. Lawrence Hospital, Lansing

Physio-Control, Grand Rapids



In This Booklet...

General Information	2	Exhibit Descriptions	30
Capsule Schedule	4	Index to Exhibitors	34
Course Details:		Special Events	35
Tuesday, November 6	6	Index to Instructors	36
Wednesday, November 7	11	Index to Cooperating Groups	37
Thursday	18	Restaurants	38
Poster Presentations	24	Entertainment	39
Exhibits Floor Plan	29		

General Information...

REGISTRATION: The registration desks are located in the Great Lakes Exhibit Center, First Floor, Hyatt Regency. Registration will open daily at 7:30 a.m. and close at 5:30 p.m.

MSMS MESSAGE CENTER: Special telephone lines have been installed for incoming, local and long distance calls. Just call the Hyatt Regency, 313/593-1234 and ask for the MSMS Message Center. Be sure you check the Message Center Board in the Exhibit Hall regularly for posted messages.

COAT CHECK: Complimentary coat check will be available adjacent to the MSMS Registration Desk and will operate at the same times. Please remember to pick up your coat before going to any evening functions. Items left at the coat check will be locked away until the following morning.

ADMISSION TO COURSES: Admission will be by Course Admission Tickets which will be given to physicians when they register. No one will be admitted to courses without tickets and/or badges. All courses begin promptly at 8:30 a.m. and 1:30 p.m.

FACULTY HEADQUARTERS: Course directors and instructors will use the Indianapolis Suite on the First Floor (near the pool) as a place to meet, review slides or course material, etc.

NO SMOKING PLEASE: All Participants are asked to refrain from smoking while courses are in session. There will be a half-hour break in all courses. The no-smoking decision has been in effect since 1977.

FREE COFFEE: Coffee will be available all three days in the Exhibit Center, compliments of exhibitors and the American Association of Medical Assistants, State of Michigan. The Medical Assistants invite all registrants to stop by during the day.

LUNCHEON TICKETS: Deli lunch tickets were offered in advance with paid registrations. A limited number of tickets may be purchased at the Registration Desk in the MSMS Exhibit Center on the First Floor.

POSTER PRESENTATION: Beginning at 8:30 a.m. on Tuesday and Wednesday you are invited to view the posters in the Main Corridor of the Regency Ballroom. Authors will be present to

discuss their posters during all refreshment and luncheon breaks both days.

EXHIBIT CENTER: Participants are urged to visit the outstanding displays featured in the Great Lakes Exhibit Center. Exhibits are open Tuesday and Wednesday from 7:30 a.m. to 6 p.m. and Thursday from 7:30 a.m. to 5 p.m. Refreshments will be provided Tuesday and Wednesday at no charge.

CATEGORY I CREDITS: The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, designates this activity meets the criteria for a maximum of 20 credit hours in Category I toward the requirements for Michigan relicensure and of the Physician Recognition Award of the AMA, provided it is completed as designed.

CERTIFICATES OF PARTICIPATION in Category I courses will be provided to physicians at the end of each course. Physicians should keep these certificates on file as proof of their attendance.

AAFP CREDIT: Members of the Michigan Academy of Family Physicians will receive Prescribed Credit for courses. MAFP members may turn in to the course assistant the AAFP computer cards, which will be forwarded to the national headquarters or MAFP members may send them direct.

MEDIA: Medical writers and representatives of television and radio have been invited to cover the Annual Scientific Meeting. MSMS staff will be available all three days in the Indianapolis Suite to assist.

ALUMNI ACTIVITIES: The Scientific Meeting is a time when graduates of the same medical schools enjoy getting together, often with one of the out-of-state speakers and the medical school deans.

This year, the Michigan State University College of Human Medicine has scheduled an open house reception on Wednesday evening November 7, beginning at 6:00 p.m.



Capsule Schedule of Annual Scientific Meeting

Tuesday, November 6

7:30 AM

Great Lakes Exhibit Center Open
Registration

8:30 AM

Concurrent Scientific Courses (run until Noon)

- Basic Cardiac Life Support
- Cardiovascular Disease & Elderly
- Rheumatology
- Immunology/Lupus
- Ovarian Cancer
- Managing Diabetes
- Pediatric Gastrointestinal Disease
- Rehabilitation/Stroke Patient

Clinical Poster Display (all day)

12 Noon

Luncheon for All Registrants

1:30 PM

Concurrent Scientific Courses (run until 5:00 p.m.)

- Arrhythmias Workshop
- Chronic Fatigue
- Lung Cancer
- Medical/Legal/Competency
- Preconception Care
- Radiology
- Substance Abuse/Children
- Suicidal Patients
- Transfusion Medicine

6:00 PM

Reception
MSMS ASM Planning Committee

Wednesday, November 7

7:00 AM

"Early Bird" Plenary Session on Rationing
Health Care
Hubbard Ballroom (Coffee & Rolls included)

7:30 AM

Great Lakes Exhibit Center Open
Registration

8:30 AM

Clinical Poster Display (all day)

Concurrent Scientific Courses (run until Noon)

- Basic Cardiac Life Support
- Surgical Problems/Infants & Children
- Thyroid Disorders
- Occupational Medicine
- Emergency Mgt./Substance Abuse
- Head & Face Pain
- Interpretation of ABG's
- Skin/Psyche/Soma
- Sports Medicine

9:00 AM

Board Meeting
Michigan Allergy Society

12 Noon

Lunch for All Registrants

Luncheon
MSMS Committee on Concerns of
Women Physicians

Luncheon
MSMS Specialty Society Presidents

Luncheon/Executive Board Meeting
Michigan Occupational Medical Association

Luncheon/Board Meeting
Michigan Physicians Mutual Liability Company



Wednesday, November 7

1:30 PM

Concurrent Scientific Courses (run until 5:00 p.m.)

- Allergy
- Breast Exam/Abnormalities
- Critical Care Medicine
- Concerns in Ethics
- Cutaneous Signs/Infectious Disease
- Environmental/Occupational
- New Applications/Narcotics
- Colon & Rectal Surgery
- Pediatric Emergencies
- Urology

3:00 PM

Board Meeting/Reception/Dinner/Program
Michigan Orthopaedic Society

5:15 PM

Business Meeting
Michigan Society of Anesthesiologists

6:00 PM

Reception
Michigan State University College of
Human Medicine Alumni Association

Reception/Dinner
Michigan Occupational Medical Association

6:30 PM

Reception/Dinner
Physician Service Group, Inc.

Reception/Dinner
Michigan Society of Colon and Rectal Surgeons

Thursday, November 8

7:00 AM

"Early Bird" Plenary Session on Caring for the
Environment
Hubbard Ballroom (Coffee & Rolls included)

7:30 AM

Great Lakes Exhibit Center Open
Registration

8:30 AM

Concurrent Scientific Courses (run until Noon)

- Caring for the Environment
- Basic Cardiac Life Support
- Atherosclerosis
- Neurology Update
- Plastic Surgery
- Performing Arts Injuries

12 Noon

Luncheon for All Registrants

1:30 PM

Concurrent Scientific Courses (run until 5:00 p.m.)

- Plastic Surgery
- Spinal Injuries
- Pulmonary Medicine
- HIV and AIDS/Primer
- Ocular Manifestations/Diabetes
- Psychopharmacology
- Women and Heart Disease
- Dizzy Patient
- Viral Hepatitis

6:00 PM

Reception/Dinner
Michigan Academy of Plastic Surgeons

Reception/Dinner/Meeting
Michigan College of Nuclear Medicine
Physicians



Tuesday morning, November 6

All courses run from 8:30 to noon with half-hour break

PHOENIX 1st Floor

Basic Cardiac Life Support

PRESENTED BY: St. Lawrence Hospital and Michigan Chapter, American College of Emergency Physicians

This course will include lectures and practical stations according to the American Heart Association guidelines for Basic Cardiac Life Support. The practical sessions will include hands-on teaching of cardiopulmonary resuscitation, obstructed airway in an unconscious and conscious victim, as well as CPR and conscious and unconscious airway obstruction for an infant. A BCLS card or Heart Saver card will be presented upon completion of the course.

COURSE DIRECTOR: Robert K. Orr, Jr., DO, Chief, Department of Medicine, St. Lawrence Hospital, Lansing

PRESIDING: Doctor Orr

FACULTY:

Greg Baker, Ambulance Director, Portland

Gwen Cowan, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Debra Deford, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Laura Lane, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Debra Seder, RN, BCLS Instructor, Saginaw

Doctor Orr

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

ATLANTA 1st Floor

Cardiovascular Disease and the Elderly

PRESENTED BY: American Heart Association of Michigan

This course will provide an overview of cardiovascular disease in the elderly, including risk factor modification, physiologic changes of aging, exercise physiology, and pharmacologic management of hypertension and ischemic syndromes. Indications for invasive and interventional maneuvers in the elderly will be discussed, including PTCA, valvuloplasty, and bypass surgery. There will also be a comprehensive overview and update on management of congestive heart failure in the elderly.

COURSE DIRECTOR: Robert N. Levin, MD, Cardiologist, William Beaumont Hospital

PRESIDING: Doctor Levin

SPEAKERS:

Doctor Levin

"Overview of Cardiovascular Disease in the Elderly"

T. Barry Levine, MD, FACC, Director, Cardiac Transplant Program and Congestive Heart Failure Service, Henry Ford Hospital, Detroit
"Management of Congestive Heart Failure in the Elderly"

Nishit Choski, MD, FACC, Director, Cardiac Step-Down Unit,

William Beaumont Hospital, Royal Oak

"Interventional Procedures in the Elderly"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

CHICAGO 1st Floor

Current Practice in Rheumatology

PRESENTED BY: Michigan Rheumatism Society

This course will concentrate on practical aspects of rheumatology. Specifically considered will be rheumatic conditions of the elderly, appropriate use of NSAID's in the '90s, nerve entrapment syndrome in the rheumatic diseases and their differentiation from joint pain, and the causes, identification, and RX of back pain from a rheumatologist's view. Discussion will emphasize an approach that is low-cost and responsive to patient needs.

COURSE DIRECTOR: Joseph J. Weiss, MD, Private Practice, Livonia

PRESIDING: Doctor Weiss

SPEAKERS:

Mark McQuillan, MD, Assistant Professor, Department of Rheumatology, University of Michigan Medical Center

"Rheumatic Conditions of the Elderly"

James C. Leisen, MD, Staff Physician, Department of Rheumatology, Henry Ford Hospital, Detroit

"Appropriate Use of NSAID's"

Doctor Weiss

"Entrapment Neuropathies in the Rheumatic Diseases"

Henry Brystowski, MD, Assistant Chief, Section of Rheumatology, Sinai Hospital of Detroit

"Back Pain - A Rheumatologist's View"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

HOUSTON 1st Floor

Immunology and Disease: Lupus, The Master Mimic

PRESENTED BY: Lupus Foundation of America, Michigan Chapter

This course, through half-hour presentations and using Systemic Lupus Erythematosus as a prototype, will instruct primary and consulting physicians in the broader aspect of the immune process in health and disease, clinical laboratory procedures in immunology and their interpretation and differential diagnosis. Also covered will be office management of the connective tissue diseases.

COURSE DIRECTOR: Samuel D. Indenbaum, MD, Clinical Associate Professor, Department of Internal Medicine, Wayne State University School of Medicine



Tuesday morning, November 6 continued

PRESIDING: *Doctor Indenbaum*

SPEAKERS:

Joseph McCune, MD, Associate Professor, Department of Medicine, University of Michigan Medical Center

"L.E.: The Master Mimic - The Disease and its Variations and Office Differential Diagnosis"

Donald B. Kaufman, MD, Professor, Department of Pediatrics and Human Development and Chief of Clinical Immunology, Michigan State University College of Human Medicine

"Vasculitis of L.E. and Other Vasculitis Syndromes"

Chaim A. Brickman, MD, Assistant Professor, Department of Medicine, Wayne State University School of Medicine; Director, Sinai Hospital Lupus Clinic

"Immunologic Overview: Understanding Basic Immunology with Emphasis on Cellular and Humoral Abnormalities in S.L.E."

Allan H. Morton, DO, Rheumatologist, Warren

"Unusual New Syndromes of S.L.E. - The Anti-Phospholipid Syndrome, AIDS & L.E., etc."

Doctor Indenbaum

"Management of S.L.E. in the Office Setting as Well as New Protocols for Life Threatening Disease"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

WASHINGTON 1st Floor

Management of Ovarian Cancer

PRESENTED BY: Department of Obstetrics and Gynecology, Hutzel Hospital

An update of information in the management of ovarian cancer, pertinent to the clinical practice of the community physician will be presented. The course outline has been derived, in great part, from inquiries made by community physicians to the participating gynecologic oncologists. Throughout the course, time will be reserved to allow exchange between the audience and the faculty.

COURSE DIRECTOR: *Gunter Deppe, MD*, Professor and Director, Division of Gynecologic Oncology, Hutzel Hospital

PRESIDING: *Doctor Deppe*

SPEAKERS:

John M. Malone, MD, Assistant Professor, Division of Gynecologic Oncology, Hutzel Hospital, Detroit

"Screening for Ovarian Cancer and Familial Ovarian Cancer"

Carl W. Christensen, MD, Assistant Professor, Division of Gynecologic Oncology, Hutzel Hospital, Detroit

"Management of Early Stage Epithelial Ovarian Cancer"

Doctor Deppe

"Surgical Management of Ovarian Cancer"

Vinay K. Malviya, MD, Associate Professor and Vice-Chief, Division of Gynecologic Oncology, Hutzel Hospital, Detroit

"Postoperative Management of Advanced Ovarian Cancer"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

DALLAS 1st Floor

Managing Diabetes in the 1990s

PRESENTED BY: American Diabetes Association, Michigan Affiliate

This course will provide primary physicians with state-of-the-art information about the practical management of diabetes mellitus with emphasis on the treatment of noninsulin-dependent and gestational diabetes. Topics to be discussed will include: epidemiology, pathogenesis, diagnosis and natural history of diabetes, treatment of diabetes, and workshop on case studies in diabetes.

COURSE DIRECTOR: *Jose Goldman, MD, PhD*, Senior Staff Physician, Department of Internal Medicine, Henry Ford Hospital, Detroit

PRESIDING: *Doctor Goldman*

SPEAKERS:

Aaron Vinik, MD, Director, The Diabetes Institute, Eastern Virginia Medical School, Norfolk, Virginia

"Epidemiology, Pathogenesis and Diagnosis of Diabetes"

Doctor Goldman

"Current Treatment of Diabetes Mellitus"

Martha Funnell, RN, MSN, CDE, Coordinator, Diabetes Research and Training Center, University of Michigan Medical School

"Diabetes Education and Dietary Management of Diabetes"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

STANLEY 2nd Floor

Pediatric Gastrointestinal Disease

PRESENTED BY: Division of Pediatric Gastroenterology, C.S. Mott Children's Hospital and University of Michigan Medical Center

This course, through one half hour case presentations, will instruct primary and consulting physicians in the nutritional principles, diagnosis, management, and prevention of malnutrition in gastrointestinal disorders. The pathophysiology of malnutrition in each disease will be examined and special nutritional approaches will be reviewed. Half of the time will be reserved for questions and discussions of participants' cases.

COURSE DIRECTOR: *Allan David Olson, MD*, Assistant Professor, Department of Gastroenterology, University of Michigan Medical Center



Tuesday morning, November 6 continued

PRESIDING: *Doctor Olson*

SPEAKERS:

Doctor Olson

"Gluten Enteropathy"

"Inflammatory Bowel Disease"

Craig A. Hillemeier, MD, Associate Professor, Department of Gastroenterology, University of Michigan Medical Center

"Cystic Fibrosis"

"Giardiasis"

Hope O'Leary, Clinical Dietitian, Department of Dietetics, University of Michigan Medical Center

"Nutritional Support for Patients with Gastrointestinal Disorders"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

SAN FRANCISCO 1st Floor

Rehabilitative Management of the Stroke Patient

PRESENTED BY: Department of Physical Medicine and Rehabilitation, WSU School of Medicine and Rehabilitation Institute, Detroit

This course will provide the primary care physician with the latest medical knowledge about several specific management issues in

the rehabilitation of the stroke patient, including: Medical management during the recovery phase; assessment of the patient for dysphagia and its complications; painful upper extremity; bowel and bladder complications; and discharge planning and use of community resources. Lecture, discussion, videotape, and hand-outs.

COURSE CO-DIRECTORS: *Fred Lamb, MD*, Assistant Professor, Department of Physical Medicine and Rehabilitation, Wayne State University School of Medicine and Medical Director, Stroke Services,

Rehabilitation Institute of Michigan, Detroit

PRESIDING: *Doctor Lamb*

SPEAKERS:

Doctor Lamb

"Problems in Medical Management"

JoAnn V. Bush, OT, Supervisor, Occupational Therapy, Rehabilitation Institute of Michigan, Detroit

"Dysphagia: Evaluation and Treatment"

Shirley Terry, RN, Nurse Manager, Rehabilitation Institute of Michigan, Detroit

"Conservative Management of Sub-acute Patients"

Anna M. Szczotka, PT, Rehabilitation Institute of Michigan, Detroit

"Progression in Functional Recovery"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

Tuesday afternoon, November 6

All courses run from 1:30 to 5 p.m. with half-hour break

ATLANTA 1st Floor

Arrhythmias Workshop

PRESENTED BY: Department of Internal Medicine, University of Michigan Medical School

This course, through three 45-minute presentations, will review the approach to diagnosis and management of syncope, paroxysmal supraventricular tachycardia and wide complex tachycardias. The role of Holter monitors, tilt table tests and electrophysiology studies will be discussed. Case studies will be presented and ample time will be allowed for discussion and questions.

COURSE DIRECTOR: *Hugh Calkins, MD*, Assistant Professor, Department of Cardiology, University of Michigan Medical Center

PRESIDING: *Doctor Calkins*

SPEAKERS:

Doctor Calkins

"New approaches to the diagnosis and management of paroxysmal supraventricular tachycardia"

Michael de Buitleir, MD, Assistant Professor, Department of

Cardiology, University of Michigan Medical Center

"Diagnosis and Management of Wide Complex Tachycardias"

Doctor Calkins

"The complementary roles of EP studies and tilt table testing in diagnosing and managing syncope"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

HOUSTON 1st Floor

Chronic Fatigue: Multi-Disciplinary Workshop

PRESENTED BY: Department of Internal Medicine, Michigan State University College of Human Medicine

At the end of the session, participants will have a rationale approach to the evaluation and treatment of patients with chronic fatigue. Specific course content will include the following: syndrome definition; physiological characteristics; epidemiology



Tuesday afternoon, November 6 continued

and demographic characteristics; psychosocial aspects; clinical evaluation; relationship to viral infections, including Epstein-Barr virus; treatment.

COURSE DIRECTOR: *Patrick C. Alguire, MD, FACP*, Professor, Department of Medicine and Program Director, Internal Medicine Residency, Michigan State University College of Human Medicine

PRESIDING: *Doctor Alguire*

SPEAKERS:

Doctor Alguire

"The Pathophysiology and Epidemiology of Chronic Fatigue"

Daniel Havlichek, MD, Assistant Professor, Department of Medicine, Michigan State University College of Human Medicine
"Chronic Fatigue" An ID Perspective"

Robert C. Smith, MD, FACP, Associate Professor, Department of Medicine, Michigan State University College of Human Medicine
"Chronic Fatigue: The Psychological Dimension and its Treatment Implications"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

STANLEY 2nd Floor

Lung Cancer

PRESENTED BY: Michigan Chapter, American College of Surgeons

This course will provide an overview on lung cancer, the number one cancer killer in the 1990s. The course is designed for both primary physicians as well as consulting physicians in any specialty who deal with the problem of lung cancer in their patients. Instructors, in three 40-minute lectures, will briefly review lung cancer as it has developed in recent decades and cover both the standard and the newest methods of approach in management of this disease. Adequate time will be allotted for interchange with attending physicians who may present specific cases of their own or prototype cases for discussion.

COURSE DIRECTOR: *Allen Silbergleit, MD, PhD*, Director, Department of Surgery, St. Joseph Mercy Hospital, Pontiac

PRESIDING: *Doctor Silbergleit*

SPEAKERS:

Doctor Silbergleit

"Overview on Lung Cancer in 1990"

Joseph Lewis, MD, Staff Surgeon, Department of Thoracic Surgery, Henry Ford Hospital, Detroit
"Surgical Approach and Management of Lung Cancer"

Manuel Valdivieso, MD, Professor, Department of Internal Medicine, Wayne State University School of Medicine
"Multimodality Therapy of Lung Cancer"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

CHICAGO 1st Floor

Medical and Legal Questions of Competency

PRESENTED BY: MSMS Committee on Aging

This course will provide the participant with information on competency, substitute decision-making and the "right to die." The new Michigan guardianship statute will be reviewed, including the appropriate use of a guardian or a conservator. The participants will learn the status of "Right to Die" legislation and how to help families cope with terminal illness. A question and answer period will follow 40-minute lectures.

COURSE DIRECTOR: *Daniel E. Leb, MD*, Director, Department of Internal Medicine Education, Pontiac General Hospital

PRESIDING: *Doctor Leb*

SPEAKERS:

Doctor Leb

"A Medical View of Competence"

Honorable John Kirkendall, Judge, Washtenaw County Probate Court

"Guardianship & Conservatorship"

"Right to Die Legislation"

Robert J. Toteff, MD, Director, Family Practice Residency, William Beaumont Hospital, Troy

"How to Communicate 'Bad News'"

Ms. Holly Turnham, Michigan Long-term Care Ombudsman, Citizens for Better Care, Lansing

"The Right to Refuse Treatment-An Advocate's Perspective"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

BUGATTI 2nd Floor

Preconception Care: Concepts and Issues

PRESENTED BY: Michigan Section, American College of Obstetricians and Gynecologists

This course consists of half-hour focus presentations, followed by a question and answer period of fifteen minutes. It is targeted to providers of health care to women in childbearing years. It emphasizes the need to encourage women to seek all available information in preparation for parenting in advance of the planned conception time. The role of pre-conception counseling in the understanding and prevention of complications of pregnancy will be emphasized. Prospective participants are encouraged to bring their own cases and clinical situations for discussion.

COURSE DIRECTOR: *Federico G. Mariona, MD*, Professor, Department of Obstetrics, Wayne State University School of Medicine; Director, Maternal and Fetal Medicine, Oakwood Hospital, Dearborn

PRESIDING: *Doctor Mariona*



Tuesday afternoon, November 6 continued

SPEAKERS:

Curtiz Meriwether, MD, Assistant Professor, Department of Obstetrics and Gynecology, Wayne State University School of Medicine
"Acute and Chronic Infections and Pregnancy Outcome"

Robert Eden, MD, Associate Professor, Department of Obstetrics and Gynecology, Wayne State University School of Medicine
"Prevent Recurrent Preterm Birth"

Doctor Mariona

"The Principles and the Issues in Preconception Counseling"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

WASHINGTON 1st Floor

Radiology for Clinicians

PRESENTED BY: Department of Radiology, Wayne State University School of Medicine

This course, through four presentations, will provide clinicians practical information in the approach of common clinical problems using various radiologic diagnostic modalities: radiologic evaluation of jaundice, evaluation of the prostate, evaluation of a breast mass and gastrointestinal bleeding.

COURSE DIRECTOR: *A. P. Zingas, MD*, Associate Professor, Department of Radiology, Wayne State University School of Medicine and *George A. Kling, MD*, Chairman, Department of Radiology, Wayne State University School of Medicine

PRESIDING: *Doctor Zingas*

SPEAKERS:

Burt T. Weyhing, MD, Assistant Professor, Department of Radiology, Wayne State University School of Medicine
"Radiologic Evaluation of Gastrointestinal Bleeding"

Myer H. Roszler, MD, Assistant Professor, Department of Radiology, Wayne State University School of Medicine
"Radiologic Evaluation of Jaundice"

Harvey Wilner, MD, Professor, Department of Radiology, Harper Hospital, Detroit
"MRI: Indications in Neurological Problems"

Mark C. Segel, MD, Assistant Professor, Department of Radiology, Wayne State University School of Medicine
"Radiologic Evaluation of Breast Masses"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

SAN FRANCISCO 1st Floor

Substance Abuse in Children

PRESENTED BY: Department of Pediatrics, Wayne State University School of Medicine

The magnitude of drug abuse and its consequences are continuing to grow. This course, through a series of 30-minute presentations,

will update practitioners on drug abuse and its consequences in children of various ages. To be discussed are: newer approaches to diagnosing substances abuse; HIV infection, its diagnosis and current therapy; and the use of drug screening in primary care settings. Indications for consultation and referral will be discussed. Upon completion of the course, attendees should be able to recognize and appropriately diagnose drug abuse in infants, school-age children and adolescents, and gain new insights into currently available therapies.

COURSE DIRECTOR: *Alan B. Gruskin, MD*, Pediatrician-in-Chief, Children's Hospital of Michigan, Detroit

PRESIDING: *Doctor Gruskin*

SPEAKERS:

Enrique Ostrea, MD, Chief, Department of Pediatrics and Neonatology, Hutzel Hospital, Detroit
"Drug Screening in the Neonate"

Flossie Cohen, MD, Director, Department of Clinical Immunology and Rheumatology, Children's Hospital of Michigan, Detroit
"Substance Abuse and Perinatal Aids"

Hugh Y. Lee, MD, Technical Director, Chemistry and Toxicology Laboratory, Damon Laboratories/Detroit Medical Center
"Drug Screening and Primary Care Practice"

Howard Schubiner, MD, Program Director of Combined Internal Medicine, Pediatric Residency Program, Children's Hospital of Michigan, Detroit

"Identifying the Drug Abusing Adolescent"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

DALLAS 1st Floor

Suicidal Patients in General Medical Practice

PRESENTED BY: Department of Psychiatry, Wayne State University School of Medicine

This course will attempt to increase the capacity of the medical practitioners in prevention, early identification and treatment of suicidal patients. The integration of the use of drugs, individual, family, group and milieu therapy will be reviewed. A one hour general review will be followed by case presentations. The last hour will be reserved for questions and discussions of participants' own cases.

COURSE DIRECTOR: *Atilla Turgay, MD*, Associate Professor, Department of Psychiatry and Director of Child Psychiatry, Wayne State University School of Medicine and Lafayette Clinic, Detroit

PRESIDING: *Doctor Turgay*

SPEAKERS:

Doctor Turgay

"Individual and Family Therapy of Suicidal Patients"

John Baugh, MD, Head, Child Inpatient Unit, Lafayette Clinic and Wayne State University School of Medicine

"Child and Adolescent Suicide: Management Issues"



Tuesday afternoon, November 6 continued

Gerald A. Shiener, MD, Associate Professor, Department of Psychiatry, Wayne State University School of Medicine and Sinai Hospital of Detroit

"Risk Recognition and Response: Drug Therapy of Suicidal Patients"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

KNIGHT 2nd Floor

Transfusion Medicine

PRESENTED BY: Department of Medicine, Section of Hematology/Oncology, Michigan State University College of Human Medicine

This course will present guidelines to prevent infection and litigation in transfusion practices, including a discussion of safety features of volunteer, autologous, and directed donor blood; and recommendations now becoming mandatory for use of blood cell and plasma products. The course also will discuss new and old anticoagulants, including mechanisms of action and appropriate use

Special Event

Clinical poster displays will be set up in the main corridor outside the course rooms from 8:30 a.m. to 5:30 p.m. on Tuesday and Wednesday. The authors will be available to discuss their work during all refreshment and luncheon breaks. After review, prizes will be awarded to the poster presenters Tuesday afternoon.

Wednesday morning, November 7

All courses run from 8:30 to noon with half-hour break

"Early Bird" Plenary Session

"Rationing Health Care"

Hubbard Ballroom

Continental Breakfast at 7:00 a.m.

Presentation at 7:15 a.m.

John O'Brien-Bell, MD

Past-President, Canadian Medical Association

Come early and have breakfast. There is no fee for this program and it offers 1 hour of Category I CME credit.

of the old (Warfarin Indandiones, Heparin) and the new (Low Molecular Weight Heparin, Antithrombin III Concentrates and Hedulin.)

COURSE DIRECTOR: *John A. Penner, MD*, Professor, Department of Medicine and Chief, Section on Hematology/Oncology, Michigan State University College of Human Medicine

PRESIDING: *Doctor Penner*

SPEAKERS:

Kenneth Schwartz, MD, Associate Professor, Department of Medicine, Michigan State University College of Human Medicine and Established Investigator, American Red Cross

"Guidelines to prevent infection and litigations"

Doctor Penner

"A Look at New and Old Anticoagulants, High and Low Molecular Weight Heparins, Antithrombin Concentrates and Hedulin"

H. Hassouna, MD, PhD, Associate Professor, Department of Medicine and Pathology; Director, Special Coagulation Laboratory, Michigan State University College of Human Medicine

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

PHOENIX 1st Floor

Basic Cardiac Life Support

PRESENTED BY: St. Lawrence Hospital and Michigan Chapter, American College of Emergency Physicians

This course will include lectures and practical stations according to the American Heart Association guidelines for Basic Cardiac Life Support. The practical sessions will include hands-on teaching of cardiopulmonary resuscitation, obstructed airway in an unconscious and conscious victim, as well as CPR and conscious and unconscious airway obstruction for an infant. A BCLS card or Heart Saver card will be presented upon completion of the course.

COURSE DIRECTOR: *Robert K. Orr, Jr., DO*, Chief, Department of Emergency Medicine, St. Lawrence Hospital, Lansing

PRESIDING: *Doctor Orr*

FACULTY:

Greg Baker, Ambulance Director, Portland

Gwen Cowan, RN, BCLS Instructor, St. Lawrence Hospital, Lansing



Wednesday morning, November 7 continued

Debra Deford, RN, BCLS Instructor, St. Lawrence Hospital, Lansing
Laura Lane, RN, BCLS Instructor, St. Lawrence Hospital, Lansing
Debra Seder, RN, BCLS Instructor, Saginaw
Doctor Orr

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

SAN FRANCISCO 1st Floor

Common Surgical Problems In Infants and Children

PRESENTED BY: Department of Pediatric Surgery, University of Michigan Medical School

This course, through four 40 minute presentations together with a discussion, will instruct primary care physicians, pediatricians, and general surgeons in the common surgical problems seen in infants and children by all these medical specialists. The definitive management of many of these problems will be discussed and those cases that require referral to a tertiary care facility will be described. At the end of the four presentations, time will be reserved for questions and discussion by the audience and the speakers.

COURSE DIRECTOR: *Arnold G. Coran, MD*, Head, Section of Pediatric Surgery, University of Michigan Medical School

PRESIDING: *Doctor Coran*

SPEAKERS:

Doctor Coran

"Abdominal Pain in Children"

Theodore Z. Polley, Jr., MD, Assistant Professor, Department of Surgery, University of Michigan Medical School
"Pediatric Trauma"

Keith T. Oldham, MD, Associate Professor, Department of Surgery, University of Michigan Medical School
"Abdominal Masses in Children"

John R. Wesley, MD, Associate Professor, Department of Surgery, University of Michigan Medical School
"Inguinal Hernias in Children"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

KNIGHT 2nd Floor

Common Thyroid Disorders: Diagnosis and Management

PRESENTED BY: Department of Nuclear Medicine, William Beaumont Hospital and Michigan Thyroid Association

This course will provide the primary care physician with current diagnostic and therapeutic information on hyperthyroidism, hypothyroidism, and thyroid nodules. The role of needle biopsy in nodule evaluation will be discussed from a medical and surgical perspective. Emphasis will be placed on proper selection of thyroid tests and avoiding pitfalls in their interpretation. Adequate time will be allotted for questions relating to any thyroid topic.

COURSE DIRECTOR: *Donald A. Meier, MD*, Staff Physician, Associated Endocrinologists and William Beaumont Hospital, Troy

PRESIDING: *Doctor Meier*

SPEAKERS:

Milton D. Gross, MD, Professor, Department of Internal Medicine, Division of Nuclear Medicine, University of Michigan Medical School

"Hyperthyroidism in the 1990's"

John E. Freitas, MD, Staff Physician, Department of Nuclear Medicine, William Beaumont Hospital, Royal Oak

"The Thyroid Nodule - Medical Perspective"

Gary B. Talpos, MD, Staff Surgeon, Department of Surgery, Henry Ford Hospital, Detroit

"The Thyroid Nodule - Surgical Perspective"

Doctor Meier

"Hyperthyroidism & Pitfalls in Interpretation of Thyroid Function Tests"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

CHICAGO 1st Floor

Doctor, Is My Work Making Me Sick?

PRESENTED BY: Michigan State University, University of Michigan and Wayne State University

This course will focus on the accurate diagnosis of occupational disease. Three perspectives will be taken, with each of the three presented by faculty at Wayne State University, the University of Michigan and Michigan State University. The course objectives are as follows: Provide the audience with skills to determine work-relatedness of medical complaints presented in the doctor's office, provide the audience with a statewide perspective on occupational disease reporting, share with the audience some "cutting edge" research pertaining to work-related disease. Attendees should complete this course with an appreciation of the magnitude of occupational disease occurrence, and the skills with which to obtain occupational histories which accurately diagnose work related conditions.

COURSE DIRECTOR: *Raymond Y. Demers, MD, MPH*, Director, Division of Occupational and Environmental Medicine, Department of Family Medicine, Wayne State University School of Medicine



Wednesday morning, November 7 continued

PRESIDING: *Doctor Demers*

SPEAKERS:

Doctor Demers

James E. Blessman, Jr., MD, MPH, Assistant Professor, Department of Family Medicine, Wayne State University School of Medicine

Alfred Franzblau, MD, MPH, Assistant Professor of Occupational Medicine, Department of Environmental and Industrial Health, University of Michigan School of Public Health

Kenneth D. Rosenman, MD, MPH, Associate Professor, Department of Medicine, Michigan State University College of Human Medicine

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

DALLAS 1st Floor

Emergency Management of Substance Abuse Patients

PRESENTED BY: Michigan Chapter, American College of Emergency Physicians

This course will focus on the patterns of substance abuse currently present in the United States and the expectation for the near future. Medical complications will be detailed as well as the emergency treatment of both abuse and abstinence syndrome.

COURSE DIRECTOR: *Gloria Kuhn, DO*, Farmington Hills

PRESIDING: *Doctor Kuhn*

SPEAKERS:

J. Ronald Oehler, MD, FACEP, Medical Director, Maple McAuley Urgent Care and Occupational Medicine Center, Ann Arbor
"Substance Abuse in the 1990's"

Bradford L. Walters, MD, FACEP, Clinical Assistant Professor, Department of Emergency Medicine, Michigan State University College of Human Medicine

"Medical Complications of Substance Abuse"

Anthony C. Southall, MD, FACEP, President, Michigan Chapter, American College of Emergency Physicians and Chief, Department of Emergency Medicine, St. John Hospital and Medical Center, Detroit

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

ATLANTA 1st Floor

Head and Face Pain: Current Concepts and Treatment Strategies

PRESENTED BY: Michigan Head Pain and Neurological Institute, Ann Arbor

This course will provide primary and consulting physicians an update on current concepts and treatment strategies for recurring head and face pain. Among topics to be considered will be basic 'work-up' and diagnostic evaluation, basic and advanced drug and non-drug treatments, the approach to analgesic overuse and dependency syndromes, regimens for acute care, role of psychological disturbances and guidelines for referral and hospitalization. Abundant time will be set aside for case discussions with audience.

COURSE DIRECTOR: *Joel R. Saper, MD*, Michigan Head Pain and Neurological Institute, Ann Arbor

PRESIDING: *Doctor Saper*

SPEAKER:

Alvin Lake, III, PhD, Chief of Psychology, Michigan Head Pain and Neurological Institute, Ann Arbor
"Non Med Therapies for Pain"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

WASHINGTON 1st Floor

Interpretation of Arterial Blood Gases

PRESENTED BY: St. Mary Hospital, Detroit

This course, through several case presentations, will instruct various aspects of interpretation of arterial blood gasses in a systematic and indepth way for primary care physicians and consultants. This is a very interactive session with faculty and participants.

COURSE DIRECTOR: *B. Babu Paidipaty, MD*, Director, Department of Critical Care Medicine and Pulmonary Medicine, St. Mary Hospital, Livonia

PRESIDING: *Doctor Paidipaty*

SPEAKERS:

Doctor Paidipaty

"Interpretation of Arterial Blood Gasses"

James Kruse, MD, Assistant Professor, Department of Medicine and Director, Department of Respiratory Therapy, Detroit Receiving Hospital

"Interpretation of Arterial Blood Gasses"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.



Wednesday morning, November 7 continued

STANLEY 2nd Floor

Skin/Psyche/Soma -- The Golden Years

PRESENTED BY: MSMS Committee on Concerns of Women Physicians

This course will focus primarily on the process of aging and the impact on three areas; skin, emotional health, and the physiological changes people incur as they age. Included in the presentations will be prevention techniques for common problems which develop as individuals age, as well as methods for handling the patient whose body and image of his/her body is changing.

COURSE DIRECTOR: *Martha L. Gray, MD*, Clinical Instructor I, Department of Internal Medicine, University of Michigan Medical School

PRESIDING: *Doctor Gray*

SPEAKERS:

Joan C. Stryker, MD, Department of Obstetrics and Gynecology, Wayne State University School of Medicine

D'Anne Kleinsmith, MD, Dermatologist, Private Practice, West Bloomfield

Cassandra M. Klyman, MD, Assistant Clinical Professor, Department of Psychiatry, Wayne State University School of Medicine

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

HOUSTON 1st Floor

Sports Medicine for Primary Care Physicians

PRESENTED BY: University of Michigan Medical School

The course will cover the diagnosis and treatment options of common injuries to the musculoskeletal system in sports with emphasis on office treatment.

COURSE CO-DIRECTORS: *Gerald A. O'Connor, MD*, Associate Professor, Department of Surgery, University of Michigan Medical School and *Edward M. Wojtys, MD*, Assistant Professor, Department of Surgery, University of Michigan Medical School

PRESIDING: *Doctors O'Connor and Wojtys*

SPEAKERS:

Doctor O'Connor

Doctor Wojtys

James Carpenter, MD, Instructor, Department of Sports Medicine, University of Michigan Hospitals, MedSport, Ann Arbor

Russell W. Miller, Lecturer in Sports Management and Communication, Division of Physical Education, University of Michigan; Supervisor, Athletic Training, Athletics and Sports Medicine, University of Michigan Hospital

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

All 51 courses offer 3 hours each of Category I credit.

Wednesday afternoon, November 7

All courses run from 1:30 to 5 p.m. with half-hour break

ATLANTA 1st Floor

Allergy 1990

PRESENTED BY: Michigan Allergy Society

This course is designed for both the allergist and non-allergist. It will provide an update on a number of timely subjects that are either allergic and immunologic or mimic allergic and immunologic clinical problems. Non-allergic conditions that present as rhinitis and asthma will be discussed as well as the use and interpretation of immunology tests. The clinical recognition, treatment and prevention strategies for radioiodinated contrast media reactions also will be reviewed. The course will utilize a lecture format with time allotted for questions.

COURSE DIRECTOR: *Carl B. Lauter, MD*, President, Michigan Allergy Society; Chief, Department of Medicine, William Beaumont Hospital, Royal Oak

PRESIDING: *Doctor Lauter*

SPEAKERS:

Chaim Brickman, MD, Chief, Department of Allergy and Immunology, Sinai Hospital of Detroit

"Immunology and Allergy Tests in Office Practice"

Lawrence I. Pasik, MD, Division of Allergy and Clinical Immunology, William Beaumont Hospital, Royal Oak

"Mimics of Allergy"

David M. Lang, MD, Division of Allergy and Immunology, Henry Ford Hospital, Detroit

"Management Treatment and Prevention of Radio/Iodinated Contrast Media Reactions"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.



Wednesday afternoon, November 7 continued

BUGATTI 2nd Floor

Breast Examination and Breast Abnormalities

PRESENTED BY: Michigan Academy of Family Physicians

This course will present a clinical, anatomical approach to breast examination. Salient embryological and anatomical features will be reviewed. Emphasis will be placed on teaching a breast examination technique and review of breast abnormalities. The course will include a television tape, slide presentation and live model demonstration.

COURSE DIRECTOR: *Richard L. Hatton, MD*, Michigan Academy of Family Physicians, Okemos

PRESIDING: *Doctor Hatton*

SPEAKER:

Doctor Hatton

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

KNIGHT 2nd Floor

Critical Care Medicine

PRESENTED BY: Michigan Society of Critical Care Medicine

This course, through half hour lectures, will instruct the primary and consulting physicians taking care of critically ill patients on current concepts of several selected topics in critical care medicine. This course will enable physicians to understand pathophysiology, complex management and recent developments in these topics. There is ample time for questions and answers.

COURSE DIRECTOR: *B. Babu Paidipaty, MD*, Director, Department of Critical Care Medicine and Pulmonary Medicine, St. Mary Hospital, Livonia

PRESIDING: *Doctor Paidipaty*

SPEAKERS:

Doctor Paidipaty

"Septic Shock"

John Popovich, MD, Chief, Department of Pulmonary and Critical Care Medicine, Henry Ford Hospital, Detroit

"A.R.D.S. - Current Concepts of Pathophysiology and Management"

Marilyn T. Haupt, MD, Director, Medical I.C.U., Wayne State University School of Medicine

"Multiple Organ Failure and Current Therapy"

James A. Kruse, MD, Director, Department of Respiratory Therapy, Wayne State University School of Medicine

"Electrolyte Emergencies"

Vinod K. Puri, MD, Director, Division of Critical Care Medicine, Providence Hospital, Southfield

"Fluid Management in Critically Ill Patients"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

CHICAGO 1st Floor

Current Concerns in Ethics

PRESENTED BY: MSMS Committee on Bioethics

Participants will be able to identify ethical issues arising in current clinical practice. From discussion, including analysis of the recent Supreme Court decision on the Cruzan case, participants will evolve approaches to the following frequent clinical dilemmas: guidelines for institutions and physicians regarding use (or non-use) of CPR; patient participation in decision making, especially when questions arise regarding the capacity of the patient to participate in health care decision making; and the means available to the physician for patients to express their wishes, including examples of advance directives (living wills, durable power of attorney) suggested for clinical use.

COURSE DIRECTOR: *John V. Hartline, MD*, Adjunct Professor, Department of Philosophy, Western Michigan University; Neonatologist, Bronson Methodist Hospital, Kalamazoo

PRESIDING: *Doctor Hartline*

SPEAKERS:

Shirley Bach, PhD, Professor, Department of Philosophy, Western Michigan University, Kalamazoo

Eugene C. Grochowski, MD, Nephrologist; and Chair, Bronson Methodist Hospital Ethics Committee, Kalamazoo

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

HOUSTON 1st Floor

Cutaneous Signs of Infectious Diseases

PRESENTED BY: Michigan Dermatological Society

This course, through illustrative and didactic presentations, will instruct and review for primary care, consulting physicians and dermatologists the application of principles pertinent to the diagnosis, treatment and prevention of selected infectious, sexually-transmitted and tropical diseases with cutaneous manifestations. Current guidelines for the management of Lyme disease, syphilis and other common dermatoses will be discussed. Upon completion of each 30 to 45-minute lecture, ample time will be reserved for questions and audience participation.



Wednesday afternoon, November 7 continued

COURSE DIRECTOR: *O. G. Rodman, MD*, Vice Chairman, Department of Dermatology, Henry Ford Hospital, Detroit

PRESIDING: *Doctor Rodman*

SPEAKERS:

Thomas A. Chapel, MD, Assistant Clinical Professor, Department of Dermatology, Wayne State University School of Medicine
"Syphyllis Update"

Daniel Connor, MD, Professor, Department of Pathology, Georgetown University Hospital, Maryland
"Common and Unusual Infectious Dermatoses"

Doctor Rodman

"Lyme Disease Update"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

ARROW 2nd Floor

Environmental and Occupational Exposures: Clinical Effects Upon Our Health

PRESENTED BY: Michigan Occupational Medical Association

Everyone is becoming more and more concerned about the health effects of the 60,000-plus chemicals used during their ordinary life activities at home as well as in the work site. There is equal concern about the quality of our air and its concentration of pollutants. This course has been structured to introduce and alert the practicing Generalist and Specialist to specific clinical ill effects they may have upon your patient so that they may be more frequently included in a differential diagnosis. It is hoped that practicing physicians will then be more apt to question patients about possible undesirable exposures where they live and work, including questions about their lifestyle.

COURSE DIRECTOR: *Martin L. Charles, MD*, President-Elect, Michigan Occupational Medical Association, Livonia

PRESIDING: *Doctor Charles*

SPEAKERS:

Doctor Charles

"Occupational/Environmental Medicine - Just What is the Connection -- How is it Practiced?"

Mark J. Upfal, MD, Assistant Professor, Department of Family Practice and Division of Occupational and Environmental Medicine, Wayne State University School of Medicine

"Environmental Exposure to Radon and Indoor Air Quality"

Hal Humphrey, PhD, Chief, Office of Science, Council for Environmental Quality, Michigan State University College of Human Medicine

"Environmental Effects on the Reproductive System"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

STANLEY 2nd Floor

New Applications for Narcotics

PRESENTED BY: Michigan Society of Anesthesiologists and the Department of Anesthesiology, University of Michigan Medical School

This course, through half-hour presentations, will acquaint primary and consulting physicians with the various methods of using narcotics for relief of both chronic and acute pain. Emphasis will be placed on newer techniques of pain relief. Case reports will be used to demonstrate the multiple benefits to both the patient and hospital from use of some of these methods. Monitoring patients when using neuroaxial narcotics also will be discussed. Time will be available for questions and answers.

COURSE DIRECTOR: *Gaylord D. Alexander, MD*, Associate Professor, Department of Anesthesiology, Sinai Hospital of Detroit

PRESIDING: *Georgine M. Steude, MD*, Assistant Professor and Interim Chair, Department of Anesthesiology, University of Michigan Medical School

SPEAKERS:

Timothy W. Rutter, MD, Associate Chair for Clinical Affairs, Department of Anesthesiology, University of Michigan Medical School

"Pharmacology of Narcotics in Pain"

Michael de Rosayro, MD, Director, Department of Obstetric Anesthesia, University of Michigan Medical School

"Intraspinal Narcotics for Obstetrics"

Blake Patterson, MD, Head of Acute Pain Service, St. Joseph Mercy Hospital, Ann Arbor

"Narcotics for Post-Traumatic and Chronic Pain"

Mark L. Gostine, MD, Clinical Instructor, Department of Anesthesiology, Michigan State University College of Human Medicine

Frederick N. Davis, MD, Clinical Instructor, Department of Anesthesiology, Michigan State University College of Human Medicine

"Intraspinal Narcotics for Post-Traumatic and Chronic Pain"

Todd Lininger, MD, Chief of Pain Management Service, Sinai Hospital of Detroit

"Risk Management and Monitoring the Patient Using Neuroaxial Narcotics"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.



Wednesday afternoon, November 7 continued

DALLAS 1st Floor

Office Practice of Colon and Rectal Surgery

PRESENTED BY: Michigan Society of Colon and Rectal Surgeons and Henry Ford Hospital

This course, by means of short lectures, will provide primary physicians basic principles for the diagnosis, management and prevention of certain colon and rectal diseases. Newer techniques of diagnosis and management will be discussed, as well as the prevention of disease. The role of consultants will be emphasized. Adequate time will be given to discuss the presentations. It is expected that the participants will leave this course with a clearer understanding of certain common colon and rectal diseases.

COURSE DIRECTOR: Thomas A. Fox, Jr., MD, Michigan Society of Colon and Rectal Surgeons, Detroit

PRESIDING: Doctor Fox

SPEAKER:

Peter A. Haas, MD, Staff Surgeon, Division of Colon and Rectal Surgery, Henry Ford Hospital, Detroit
"Hemorrhoid"

Steven N. Klein, MD, Staff Surgeon, Department of Colon and Rectal Surgery, William Beaumont Hospital, Royal Oak
"Anal Fissures"

Martin A. Luchtefeld, MD, Staff Surgeon, Department of Colon and Rectal Surgery, The Ferguson Clinic For Digestive Diseases, Grand Rapids
"Perianal Abscess and Fistulas"

Eric J. Szilagyi, MD, Staff Surgeon, Department of Colon and Rectal Surgery, Henry Ford Hospital, Detroit
"Rigid and Fiberoptic Flexible Sigmoidoscopy"

William L. Beauregard, MD, Staff Surgeon, Department of Colon and Rectal Surgery, William Beaumont Hospital, Royal Oak
"Video Endoscopy"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

SAN FRANCISCO 1st Floor

Pediatric Emergencies

PRESENTED BY: Department of Critical Care Medicine, Children's Hospital of Michigan, Detroit

This course, through 35-40 minute sessions, is on commonly encountered pediatric emergencies in an office or hospital setting. The role of the primary care and emergency physician in the diagnosis and management of airway obstruction, evaluation of a febrile child, principles of fluid resuscitation, and approach to common poisonings will be covered. Indications for various therapeutic strategies and referrals will be discussed. The course

participants will be able to discuss issues involving pediatric emergency care with the faculty.

COURSE DIRECTOR: Ashok P. Sarnaik, MD, Division Chief, Department of Critical Care Medicine, Children's Hospital of Michigan, Detroit

PRESIDING: Doctor Sarnaik

SPEAKERS:

Doctor Sarnaik

"Evaluation and Management of Airway Obstruction"

Norman Rosenberg, DO, Director, Department of Emergency Medicine, Children's Hospital of Michigan, Detroit
"Febrile Infant"

Mary Lieh-Lai, MD, Director, ICU, Children's Hospital of Michigan, Detroit

"Commonly Encountered Poisonings"

Stephen Knazik, DO, Staff Physician, Department of Emergency Medicine, Children's Hospital of Michigan, Detroit

"Commonly Encountered Poisonings"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

WASHINGTON 1st Floor

What's New in Urology

PRESENTED BY: Department of Urology, Wayne State University School of Medicine and Michigan Urological Society

This course, designed for urologists and primary care physicians, will present updates and new developments in origins of cancer-oncogenes, prostate cancer, management of advanced kidney cancer, treatment of urinary stone disease and the significance of antenatal hydrocephrosis.

COURSE DIRECTOR: Isaac J. Powell, MD, Assistant Professor, Department of Urology, Wayne State University School of Medicine

PRESIDING: Doctor Powell

SPEAKERS:

Herbert Lepor, MD

Doctor Powell

J. Edson Pontes, MD

Gabriel P. Haas, MD, Assistant Professor - Clinical, Department of Urology, Wayne State University School of Medicine

Claude Reitelman, MD, Assistant Professor, Department of Urology, Wayne State University School of Medicine

James B. Smith, Jr., MD, Assistant Professor, Department of Urology, Wayne State University School of Medicine

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.



Thursday morning, November 8

All courses run from 8:30 to noon with half-hour break

"Early Bird" Plenary Session

"Caring for the Environment"

Hubbard Ballroom
Continental Breakfast at 7:00 a.m.
Presentation at 7:15 a.m.

Vernon Houk, MD, MPH, Assistant Surgeon General, Director, Center for Environmental Health, Centers for Disease Control, Atlanta

This session serves as the "kick-off" event for a half-day plenary on environmental issues and the role physicians play as caretakers. Come early and have breakfast. There is no fee for this portion and it offers 1 hour of Category I CME credit.

PHOENIX 1st Floor

Basic Cardiac Life Support

PRESENTED BY: St. Lawrence Hospital and Michigan Chapter, American College of Emergency Physicians

This course will include lectures and practical stations according to the American Heart Association guidelines for Basic Cardiac Life Support. The practical sessions will include hands-on teaching of cardiopulmonary resuscitation, obstructed airway in an unconscious and conscious victim, as well as CPR and conscious and unconscious airway obstruction for an infant. A BCLS card or Heart Saver card will be presented upon completion of the course.

COURSE DIRECTOR: Robert K. Orr, Jr., DO, Chief, Department of Emergency Medicine, St. Lawrence Hospital, Lansing

PRESIDING: Doctor Orr

FACULTY:
Greg Baker, Ambulance Director, Portland
Gwen Cowan, RN, BCLS Instructor, St. Lawrence Hospital, Lansing
Debra Deford, RN, BCLS Instructor, St. Lawrence Hospital, Lansing
Laura Lane, RN, BCLS Instructor, St. Lawrence Hospital, Lansing
Debra Seder, RN, BCLS Instructor, Saginaw
Doctor Orr

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

ATLANTA/CHICAGO 1st Floor

Caring for the Environment

PRESENTED BY: MSMS Liaison Committee with Michigan Department of Public Health and MSMS Task Force on Environment and Health

A special plenary session on environmental issues will be conducted. Preliminary topics will include the role of physicians in their communities, toxics in the home and workplace, medical waste, and the status of Michigan's environment.

INTRODUCTION: Susan H. Adelman, MD, President, Michigan State Medical Society

The session will continue from 8:30 until noon with presentations and a panel discussion. There will be time for a question-and-answer session afterward.

PRESENTATIONS AND PANEL: Moderated by Kenneth Rowe, MD, MSMS representative to the Council on Environmental Quality.

Panelists include:
Raj M Wiener, Director, Michigan Department of Public Health
Burton D. Cardwell, PhD, Chief Deputy Director, Michigan Department of Agriculture
Lynelle Marolf, Assistant to Deputy Director of Environmental Protection
Doctor Houk, CDC, Atlanta
Mark J. Upfal, MD, Assistant Professor, Department of Family Practice and Division of Occupational and Environmental Medicine, Wayne State University School of Medicine

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

WASHINGTON 1st Floor

Controversies in Atherosclerosis

PRESENTED BY: Michigan Society of Critical Care Medicine

This advanced course is for physicians taking care of patients with carotid artery disorder and coronary artery disease. This course will provide practical information about medical and surgical management and controversies of these diseases in lecture form. It will provide current approach to the management of these diseases. There will be ample time for audience participation.

COURSE DIRECTOR: B. Babu Paidipaty, MD, Director, Department of Critical Care Medicine and Pulmonary Medicine, St Mary Hospital, Livonia

PRESIDING: Doctor Paidipaty

SPEAKERS:
James I. Ausman, MD, MA, PhD, Chairman, Department of Neurosurgery, Henry Ford Hospital, Detroit
"The Surgical Management of Carotid Artery Disease - Advantages Over Medical Management"



Thursday morning, November 8 continued

Mark Chimowitz, MD, Chief, Stroke Unit - Department of Neurology, University of Michigan Medical Center

"Medical Management of Carotid Artery Disease and its Advantages Over Surgical Management"

Joshua Wynne, MD, Chief, Division of Cardiology, Wayne State University School of Medicine

"Medical Management of Coronary Artery Diseases and Advantages Over Surgical Management"

D. Larry Stephenson, MD, Division of Cardiovascular Surgery, Wayne State University School of Medicine

"Surgical Management of Coronary Artery Diseases and Advantages Over Medical Management"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

HOUSTON 1st Floor

Neurology Update: Parkinson's Disease, Headaches, Dementia and Neuropathy

PRESENTED BY: Department of Neurology, Wayne State University School of Medicine

This course will provide a review and update highlighting these four topics of general interest to inpatient and office practice. Each topic will be reviewed from the standpoint of diagnostic measures and differential diagnosis, as well as therapeutic interventions and controversies. Opportunities will be available for presentation of case material and questions from the audience. Primary practitioners should come away from this course with skills for their own management of these common disorders.

COURSE DIRECTOR: *Peter A. LeWitt, MD*, Director, Clinical Neuroscience, Movement Disorders Clinic, Sinai Hospital of Detroit

PRESIDING: *Doctor LeWitt*

SPEAKERS:

Doctor LeWitt

"Update on Parkinson's Disease"

Joshua Adler, MD, PhD, Associate Professor, Department of Neurology, Wayne State University School of Medicine

"Dementia and Other Cognitive Disorders"

Robert P. Lisak, MD, Professor and Chairman, Department of Neurology, Wayne State University School of Medicine

"Peripheral Neuropathy Update"

Paul A. Cullis, MD, Clinical Associate Professor, Department of Neurology, Wayne State University School of Medicine

"Migraines and Other Headaches"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

SAN FRANCISCO 1st Floor

Performing Arts Injuries

PRESENTED BY: Department of Physical Medicine and Rehabilitation, University of Michigan Medical School

This course is aimed at primary care physicians with an interest in performing arts-related medical problems. Upon completion of the course, the physician will have an overview of the diagnosis and treatment of physical and psychological problems facing performers, particularly dancers and instrumentalists. A professional dancer will also lend his perspective on dance injuries, their treatment and their impact on the performer.

COURSE DIRECTOR: *Steve R. Geiringer, MD*, Assistant Professor, Department of Physical Medicine and Rehabilitation, University of Michigan Medical School

PRESIDING: *Doctor Geiringer*

SPEAKERS:

Doctor Geiringer

"Performing Arts Injuries - Upper Extremity"

Julie J. Nagel, Consultant, ArtsMed, Department of Psychology, University of Michigan

"Performance Anxiety and Stage Fright"

Peter D. Sparling, Chair, Department of Dance, University of Michigan

"Dance Injuries - The Dancer's Perspective"

Doctor Geiringer

"Performing Arts Injuries - Lower Extremity"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

DALLAS 1st Floor

Priorities In Microsurgical Repair -- Upper Extremity

PRESENTED BY: Michigan Academy of Plastic Surgeons

This course is directed toward surgeons (general, plastic and orthopaedic) and residents in training who must organize the treatment of injuries of the extremities from the initial injury to the final result. General principles will be developed which can be applied to individual cases.

COURSE DIRECTOR: *Donald M. Ditmars, Jr., MD*, Henry Ford Hospital, Detroit

PRESIDING: *Doctor Ditmars*

SPEAKERS:

Charles J. Eaton, MD, Assistant Professor, Department of Plastic Surgery, University of Utah School of Medicine, Salt Lake City, Utah

"Priorities in Repair and Reconstruction of Extremities"



Thursday morning, November 8 continued

Peter K. Janevski, MD, Hand Surgeon, Henry Ford Hospital, Detroit

"Reflex Sympathetic Dystrophy"

Doctor Eaton

"Microsurgical Reconstruction of the Upper Extremity"

Herman P. Houin, MD, Plastic Surgeon, Department of Plastic and

Reconstructive Surgery, Henry Ford Hospital, Detroit
"The Donor Site in Radial Forearm Free Flaps"

Mune Gowda, MD, Plastic Surgeon, Providence Hospital, Southfield

"Review of Free Flaps - 80 Cases"

This program has been reviewed and is acceptable for 3 Elective hours by the American Academy of Family Physicians.

Thursday afternoon, November 8

All courses run from 1:30 to 5 p.m. with half-hour break

SAN FRANCISCO 1st Floor

A New Look at Clinical Problems in Plastic Surgery

PRESENTED BY: Michigan Academy of Plastic Surgeons

A series of papers from the Providence Hospital Plastic Surgery Program outlining clinical and laboratory research considerations of reconstructive problems will be presented. This course is directed toward practicing plastic and hand surgeons and residents in training.

COURSE DIRECTOR: *Donald M. Ditmars, Jr., MD*, Department of Plastic Surgery, Henry Ford Hospital, Detroit

PRESIDING: *David B. Hawtof, MD*, Program Director, Plastic Surgery Residency Program, Providence Hospital, Southfield

SPEAKERS:

Charles J. Eaton, MD, Assistant Professor, Department of Plastic Surgery, University of Utah School of Medicine

"Current Techniques in Flexor Tendon Repair"

Keizo Fukuta, MD, Associate Research Fellow, Department of Plastic Surgery, Craniofacial Institute, Providence Hospital, Southfield

"Facial Skin Tension Lines"

David B. Hawtof, MD, Program Director, Plastic Surgery Residency Program, Department of Plastic Surgery, Providence Hospital, Southfield

"Laser Burns in GYN Patients"

Adrian Lo, MD, Research Fellow, Institute for Craniofacial & Reconstructive Surgery - Providence Hospital, Southfield

"Orbital Bone Growth by Tissue Expansion"

Marcus Collares, MD, Research Fellow, Institute for Craniofacial & Reconstructive Surgery - Providence Hospital, Southfield

"The Use of Hydroxyapatite and Proplast for the Reconstruction of Facial Disorders"

Yaron Har-Shai, MD, Research Fellow, Institute for Craniofacial and Reconstructive Surgery, Providence Hospital, Southfield

"The Management of Soft Tissue Complications Related to Pacemaker Implantations"

Jay Ross, MD, Resident, Department of Plastic Surgery, Providence Hospital, Southfield

"Vascularized Bone Grafts for Oral and Nasal Cavity Reconstruction"

This program has been reviewed and is acceptable for 3 Elective hours by the American Academy of Family Physicians.

ARROW 2nd Floor

Acute Spinal Injuries: Emergency Room Through Rehabilitation

PRESENTED BY: Department of Neurosurgery, University of Michigan Medical School

This course will review the management of acute spine injuries, including emergency room treatment and diagnosis, radiology of the spine, surgical interventions, and rehabilitation. The course participants will include faculty members from the University of Michigan section of neurosurgery, emergency medicine, radiology, and spinal cord injury rehabilitation.

COURSE DIRECTOR: *Stephen M. Papadopoulos, MD*, Assistant Professor, Department of Neurosurgery, University of Michigan Medical Center

PRESIDING: *Doctor Papadopolous*

SPEAKERS:

Doctor Papadopolous

"Introduction and Acute Treatment of Spine Injuries"

Stephen S. Gebarski, MD, Associate Professor, Department of Neuroradiology, University of Michigan Medical Center

"Radiologic Evaluation of Spine Injuries"

Jorge Rodriguez, MD, Assistant Professor, Department of Trauma/Critical Care, University of Michigan Medical Center

"Associated Injuries and Other Considerations"

Frederick Maynard, MD, Associate Professor, Department of Physical Medicine and Rehabilitation, University of Michigan Medical Center

"Rehabilitation and Outcome"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.



ATLANTA 1st Floor

HIV and AIDS: Outpatient Primer

PRESENTED BY: MSMS AIDS Provider Education Project and Wayne State University School of Medicine

This course will provide pragmatic information for the primary care physician on the outpatient management of HIV infection and AIDS. Using case presentations, four half-hour segments on HIV testing, laboratory test interpretation, common signs and symptoms, and management of HIV disease and its complications will be discussed. Ample time will be reserved for questions and discussion of the participants own cases. At the end of this course, primary care physicians should be competent to manage the common complications of HIV infection in their office.

COURSE DIRECTOR: Lawrence R. Crane, MD, Associate Professor, Department of Medicine, Wayne State University School of Medicine

PRESIDING: Doctor Crane

SPEAKERS:

Doctor Crane

“Office Based Counseling and Testing for HIV”

Charles Craig, MD, Department of Infectious Disease, St. Joseph Hospital, Ann Arbor

“The Laboratory Evaluation of HIV Infected Persons”

Paula Schuman, MD, Assistant Professor, Department of Medicine, Wayne State University School of Medicine

“Recognition, Management of Common Outpatient Infections”

Jack Ebright, MD, Associate Professor, Department of Medicine, Wayne State University School of Medicine

“Antiretroviral Therapy in the Office”

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

KNIGHT 2nd Floor

Ocular Manifestations of Diabetes

PRESENTED BY: Michigan Ophthalmological Society

In the past several years, significant advances have been made in our understanding of the pathogenesis and treatment of diabetic eye disease. Many of these advances are based on recently completed clinical trials. This course will present a state-of-the-art review of diabetic eye disease with emphasis on pathogenesis, diagnosis and treatment.

COURSE DIRECTOR: George A. Williams, MD, Associate Professor, Department of Ophthalmology, Oakland University; Michigan Ophthalmological Society

PRESIDING: Doctor Williams

SPEAKERS:

Deborah Iverson, MD, Assistant Professor, Department of Ophthalmology, Wayne State University School of Medicine; Michigan Ophthalmological Society

Scott R. Sneed, MD, Assistant Professor, Department of Ophthalmology, University of Michigan Medical School; Michigan Ophthalmological Society

Alan Spigelman, MD, Michigan Ophthalmological Society, Livonia

Doctor Williams

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

CHICAGO 1st Floor

Potpourri of Pulmonary Problems

PRESENTED BY: Department of Medical Education, Oakwood Hospital, Dearborn

This course will focus on several topics of importance in ambulatory pulmonary medicine. Speakers will discuss new concepts in upper respiratory infections including epiglottitis in the adult, as well as the approach to ambulatory patients with pneumonia. The problems of chronic cough and snoring will be reviewed and current practices in the diagnosis and management of rib fractures and chest contusions will be discussed.

COURSE CO-DIRECTORS: Lyle D. Victor, MD, Director, Transitional Residency, Department of Pulmonary Medicine, Oakwood Hospital, Dearborn and Nicholas Lekas, MD, Director, Internal Medicine Residency, Department of Infectious Diseases, Oakwood Hospital, Dearborn

PRESIDING: Doctors Victor and Lekas

SPEAKERS:

Angela DeSantis, MD, Internal Medicine Senior Resident, Department of Internal Medicine, Oakwood Hospital, Dearborn

“The Patient with Chronic Cough”

Doctor Victor

“Snoring - Implications in Adult Medicine”

Nancy McGuire, MD, Assistant Professor, Department of Medicine, Wayne State University School of Medicine

“Upper Respiratory Infections in the Adult”

Doctor Lekas

“Ambulatory Pneumonia”

Paul W. Haydon, MD, Assistant Director, Medical Education, Department of Internal Medicine, Oakwood Hospital, Dearborn

“Outpatient Chest Trauma - Fractured Ribs and Contusions”

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.



Thursday afternoon, November 8 continued

DALLAS 1st Floor

Psychopharmacology for the Non-Psychiatrist

PRESENTED BY: Department of Psychiatry, University of Michigan Medical School

This course will present an overview of the clinical pharmacology and uses of the major psychotropic drug classes followed by a presentation on psychopharmacology in the elderly. The half-hour presentations will provide participants with the knowledge necessary to identify the indications for psychotropic drug use as well as to prescribe and monitor them in a safe and effective manner in the primary care setting. Common pitfalls and issues of non-compliance associated with maintenance treatment will also be covered. Ample time will be allowed for questions and discussion of case vignettes.

COURSE CO-DIRECTORS: *John F. Greden, MD*, Professor and Chair, Department of Psychiatry and Research Scientist, Mental Health Research Institute, University of Michigan Medical School and *Atul C. Pande, MD*, Assistant Professor, Department of Psychiatry, University of Michigan Medical School

PRESIDING: *Doctor Greden*

SPEAKERS:

Oliver G. Cameron, MD, Associate Professor, Department of Psychiatry, University of Michigan Medical School
“Benzodiazepine Use in Primary Care”

Rajiv Tandon, MD, Assistant Professor, Department of Psychiatry, University of Michigan Medical School
“Neuroleptic Therapy”

Doctor Pande
“Uses and Misuses of Antidepressants”

Leon J. Grunhaus, MD, Associate Professor, Department of Psychiatry, University of Michigan Medical School
“Psychotropic Drug Use in the Elderly”

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

STANLEY 2nd Floor

Silent Epidemic: The Truth About Women and Heart Disease

PRESENTED BY: American Heart Association of Michigan

This course is directed to internists and family practitioners. Upon completion of this course physicians will recognize 1) the roles of various risk factors in the development of coronary artery disease

in women, 2) learn about the effects of various sex steroids on lipid metabolism, and 3) recognize the benefits and shortcomings of various methods used in the diagnosis of coronary artery disease.

COURSE DIRECTOR: *Sidika Kasim, MD*, Assistant Professor, Department of Medicine, Wayne State University School of Medicine

PRESIDING: *Doctor Kasim*

SPEAKERS:

Marriyam Moten, MD, Assistant Professor, Department of Medicine, Wayne State University School of Medicine
“Modification of Coronary Artery Disease Risk Factors in Women”

Doctor Kasim
“Management of Lipid Disorders in Women”

Pamela R. Gordon, MD, Assistant Professor, Department of Medicine, Wayne State University School of Medicine
“Diagnosis and Management of Coronary Artery Disease in Women”

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

WASHINGTON 1st Floor

The ABC (DE)'s of Viral Hepatitis

PRESENTED BY: Department of Medicine, Wayne State University School of Medicine

The course will update generalists and specialists on the various defined types of viral hepatitis. Clinical aspects will be emphasized, including the ordering and interpretation of serological tests, the principles of prophylaxis, and the medical and surgical treatment of acute and chronic disease. There will be ample time for questions.

COURSE DIRECTOR: *Murray N. Ehrinpreis, MD*, Associate Professor and Acting Director, Division of Gastroenterology, Wayne State University School of Medicine and Harper Hospital

PRESIDING: *Doctor Ehrinpreis*

SPEAKERS:

Doctor Ehrinpreis
“Natural History and Prophylaxis of Viral Hepatitis”

Ann L. Silverman, MD, Assistant Professor, Division of Gastroenterology, Wayne State University School of Medicine and Harper Hospital

“Ordering and Interpreting Serological Tests in Viral Hepatitis”

Milton G. Mutchnick, MD, Associate Professor, Division of Gastroenterology, Wayne State University School of Medicine; Chief of Gastroenterology, Hutzel Hospital
“Medical Therapy of Chronic Viral Hepatitis”



Thursday afternoon, November 8 continued

Rene R. Peleman, MD, Assistant Professor, Division of Gastroenterology, Wayne State University School of Medicine; Chief of Gastroenterology, Detroit Receiving Hospital

"Hepatic Transplantation in Acute and Chronic Viral Hepatitis"

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

HOUSTON 1st Floor

The Dizzy Patient: Evaluation and Treatment

PRESENTED BY: EAR Consultants of Michigan

This course will give physicians a better understanding of the types of dizziness, methods for evaluating the dizzy patient and treatment including medical and surgical options and rehabilitative strategies.

COURSE CO-DIRECTORS: *Dennis I. Bojrab, MD* and *Charles Stockwell, PhD, Royal Oak*

PRESIDING: *Doctors Bojrab and Stockwell*

SPEAKERS:

Doctor Bojrab

Doctor Stockwell

This program has been reviewed and is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

All 51 courses offer 3 hours each of Category I credit.





Clinical Poster Presentations

1990 MSMS Annual Scientific Meeting

November 6 & 7

Hyatt Regency Dearborn

8:30 a.m. to 5:30 p.m.

Main Corridor, Regency Ballroom

Poster displays will be set up beginning at 8:30 a.m., November 6 and 7. Authors will be available to discuss their posters during all refreshment and luncheon breaks both days.

1. A Comparison of Carbon Monoxide Diffusing Capacity and Exercise Pulse Oximetry in the Assessment of Interstitial Lung Disease.

Brent VanHoozen, MD; R. Klimek, MD, Department of Medicine, Michigan State University, East Lansing

Interstitial lung disease provides assessment challenges to physicians wishing to evaluate disease progression and physiological impact on the patient. Carbon monoxide diffusing capacity (D_LCO) has long been used as a marker of disease extent and progression, but recently, exercise pulse oximetry (ExOx) has been advocated as a more useful test for functional assessment of patients with interstitial lung disease. The purpose of this study was to compare the relative sensitivities of D_LCO and ExOx in measuring impairment of oxygenation in patients with interstitial lung disease. The study was a retrospective analysis of patients undergoing D_LCO and ExOx between January 1986-January 1990 in the pulmonary function laboratory of a 400 bed community teaching hospital. Of 131 patients who met this criteria, 40 had well documented interstitial lung disease and were included in the study. The subjects' D_LCO was compared to their ExOx during a standardized exercise protocol. Overall concordance between the two tests was 75%, but fell to 56% when the D_LCO was "corrected" for alveolar volume. ExOx identified 12 subjects with significant desaturation despite normal "corrected" D_LCO measurements. Using ExOx as the "Gold Standard" for identifying clinically important oxygenation impairment in patients with interstitial lung disease, the sensitivity and specificity of D_LCO were 91% and 50% respectively. The positive and negative predictive values were 72% and 80%. The sensitivity and specificity for "corrected" D_LCO was 43% and 75% respectively with positive and negative predictive values of 71% and 52%. These findings suggest that D_LCO has insufficient sensitivity and specificity to correctly identify subjects with clinically important oxygenation impairment with interstitial lung disease as compared to ExOx.

2. Comparison of the FLM^R Test, Lamellar Bodies and Lecithin: Sphingomyelin Ratio in Amniotic Fluid from Non-Diabetic and Diabetic Patients.

E. Sykes, MD; C. Michael, MD; R. Karcher, PhD; C. Sloan, MD; S. Collins, MT (ASCP); J. Rogers, MT (ASCP); E. Epstein, PhD; J. Mattson, MD; F. Kiechle, MD, PhD, Department of Clinical Pathology, William Beaumont Hospital, Royal Oak

We tested 106 amniotic fluids for fetal lung maturity using FLM^R values from the Abbott TDXR, lamellar bodies (LB) quantitated by resistive-pulse counting on a Coulter S-PLUS VR, and lecithin: sphingomyelin (LS) ratio and % phosphatidylglycerol (PG) by the Gluck chromatographic procedure. Results from 19 diabetic cases in the group were also compared to gestational age-matched non-diabetic controls. No significant difference was found by paired t test for filtered vs. centrifuged samples in the FLM test ($y=.93+0.25$, $r=.909$, $n=20$), but the difference between centrifuged and uncentrifuged specimens for LB results was slightly significant ($p<0.05$, $y=.94x-0.6$, $r=.958$, $n=40$). Using the LS ratio as reference value, the FLM correlated better ($r=.834$, $n=78$) than did the uncentrifuged LB values ($r=.696$, $n=40$). The FLM and LB values correlated best, however, ($r=0.860$, $n=29$) and showed surprising numerical equivalence ($y=1.0x-9.5$). Using the paired t test, a significant difference ($p<0.001$) was found between FLMs in 17 pairs of diabetics (mean=74.8, range 36.8-151.4) and non-diabetic controls (mean=74.8, range 36.4-121.1), but no significant difference was found between LS ratios and % PG in 19 matched pairs. Numbers of LB in the matched diabetic/non-diabetic groups were too small for comparison. In addition to the findings described above on all cases, our limited study of diabetic patients suggests that the reference limits for the FLM test may be higher in diabetics than in non-diabetic patients.

3. Diagnosis of Ruptured Breast Implants.

David B. Hawtof, MD; Blaine Anderson, MD, Providence Hospital, Southfield

Diagnosis of ruptured breast implants can be difficult for radiologists and surgeons. This study establishes criteria to facilitate diagnosis of ruptured breast implants by retrospective analysis of patients treated by the authors and cases reported in the literature. Cases analyzed include 18 patients treated by the authors from 1978 to 1988 and 14 cases reported from 1977 to 1987.

A history of trauma was absent in eleven patients. Seventeen patients had closed capsulotomies. The physical findings of rupture were subcutaneous nodules, decreased breast size, asymmetry, tenderness and softer texture. One patient had cancer in a breast contralateral to a broken implant. Mammograms were 90% sensitive when silicone had migrated into the soft tissue. In seven of eight false negative mammograms, the silicone was contained in the fibrous capsule. Mammography signs of ruptured implants are summarized and illustrated. The morbidity of silicone extravasated into the soft tissue is minimal.

We conclude a history of trauma is not necessary to make a diagnosis of rupture, ruptured breast implants can present with a variety of signs and symptoms, mammography is a good screening test, masses in the breast and axilla should be biopsied. The diagnosis of ruptured breast implants should be facilitated by recognition of known clinical presentations and radiographic signs.



4. Disseminated Strongyloides in a Patient on Steroids for Bronchiolitis Obliterans and Organizing Pneumonia in a Non-Endemic Area.

John Siano, MD, Department of Medicine, Michigan State University, East Lansing

In the United States strongyloides stercoralis is endemic in the Southeast. This is a case report of disseminated strongyloides in a non-endemic area. After being placed on steroids for bronchiolitis obliterans and organizing pneumonia, a 63 year old caucasian male developed severe pneumonitis leading to respiratory failure and requiring ventilator support, cardiogenic shock and encephalopathy. Strongyloides stercoralis was isolated from a sputum specimen. All cultures from blood, stool and cerebral spinal fluid remained negative. The patient remained critically ill for three months and spent a total of 163 days in the hospital of which 71 days were spent in a rehabilitation unit. He was treated with three weeks of Thiabendazole therapy. This case and a review of the literature indicates that immunocompromised hosts are more susceptible to disseminated strongyloides stercoralis. Disseminated strongyloides can occur in any geographic area; it may be associated with congestive heart failure, severe pneumonitis, and encephalopathy. This case is important for reminding physicians that common diseases may occasionally have uncommon etiologies.

5. Eosinophilic Granulomatous Vasculitis Secondary to Phenytoin; An Unusual Cause of Renal Failure.

Martha Pollock, MD; Daniel Dubay, MD and John Speck, MD, William Beaumont Hospital, Royal Oak

Eosinophilic granulomatous vasculitis is a rare cause of renal failure. It is usually seen in association with Churg-Strauss Syndrome but occasionally has been reported as a drug hypersensitivity reaction. We present a case of eosinophilic granulomatous vasculitis secondary to phenytoin.

A 75 year old black female with a history of angina, diabetes, hypertension and hypothyroidism was admitted for control of her diabetes. She was feeling weak on admission but had no other complaints. Dilantin had been started two months prior to admission for peripheral neuropathy. During her hospital course, the patient developed a rash, eosinophilia, eosinophiluria, and progressive renal failure requiring peritoneal dialysis. A renal biopsy showed eosinophilic granulomatous vasculitis. The patient had been taking dyazide and clinoril for several years which were discontinued without improvement. Three days after discontinuing phenytoin and after a short course of steroids, the patients renal function began to improve and she was subsequently discharged home in her previous state of health.

We conclude that phenytoin is a potential cause of eosinophilic granulomatous vasculitis. This is probably the third reported case of eosinophilic granulomatous vasculitis secondary to phenytoin.

6. Fatal Ingestion from Sustained Release Verapamil.

Diane MacDonald, MD; L. Wulfekhuler, MD, Department of Medicine, Michigan State University, East Lansing

Calcium channel blockers, a common cardiovascular medication, are generally safe. When taken in large quantities they can lead to AV conduction disturbances, hypotension, metabolic acidosis and hyperglycemia. Death is an uncommon occurrence secondary to overdose of calcium channel blocking medications and definitive treatment is still unknown. The case presented is a 27 year old caucasian female who ingested an unknown quantity of sustained release verapamil (240mgs) as well as multiple other compounds (Librium, Darvon, erythromycin and Zantac). She was brought to the emergency department, an undisclosed amount of time after ingestion, unconscious, hypotensive and bradycardia; she was in 3° AV block. External pacemaker, calcium gluconate, Narcan, charcoal and dopamine were initial treatments. While the patient did become responsive, her cardiac rhythm was a junctional bradycardia of 55; she was also anuric and required hemodialysis. On hospital day 2, vital signs and cardiac rhythm were unable to be maintained despite resuscitative measures and the patient expired. Admission verapamil levels were 2135ng/ml and N-desmethyl verapamil was 795. Effective range for both is 100-300 ng/ml. Calcium channel blockers interfere with entry of calcium into cells, particularly SA and AV nodal tissues and vascular smooth muscle. The resultant effect is vascular and coronary artery vasodilation and slowed conduction. Other effects include impaired release of insulin from pancreatic beta cells. Many treatments have been recommended for toxicity including cardiac pacing, calcium, atropine, glucagon. B₂ agonist, inotropic agents and 4-aminopyridine. However, no consistent successful therapy has emerged. Cause of death is usually secondary to inability to maintain adequate blood pressure or a normal cardiac rhythm. This case is important because of the increasing use of calcium channel blockers for various medical conditions and lack of definitive treatment of toxicity from this class of drug.

7. Inflammation of the Gastrointestinal Mucosa in Children Evaluated for Suspected Functional Recurrent Abdominal Pain.

Ronald Holmes, MD and Jonna Schmidt, MD, William Beaumont Hospital, Royal Oak

The purpose of this study was to determine the incidence of unsuspected mucosal inflammation in children referred for evaluation of recurrent abdominal pain of childhood (RAPC). Esophagogastroduodenoscopy was performed on 20 children (9M and 11F), age 4.1 to 17.2 years who had RAPC without apparent signs or symptoms of underlying organic disease. None of the patients were taking medications known to cause inflammation of the gastrointestinal tract. Biopsies from the gastric antrum and/or sites of apparent endoscopic inflammation were obtained for later histopathologic study. Additional gastric biopsies were taken for silver stain and Haemophilus pylori culture. Endoscopic inflammation (EI) was present in 17 patients (85%) and 11 of 17 (65%) had histopathologic inflammation (HI). Results (Table):

Site	EI	HI
Esophagitis	6	4
Gastritis	12	5
Duodenitis	10	6



Clinical Poster Presentations continued

Haemophilus pylori was not identified in any child with histologic gastritis. There was incomplete correlation between endoscopic appearance and histologic findings.

In summary, 11 of 20 (55%) of the patients with suspected functional RAPC had obvious histologic inflammation of the gastrointestinal mucosa. We conclude that a specific subset of children with RAPC have demonstrable gastrointestinal disease.

8. Intravenous Histamine 2 Antagonist Receptor Use in a Community Hospital.

Marcia Doebling-Skjaerlund, DO; James E. Mayle, MD; J. VanderLind, PharmD and Susan Fehr, RPh, Department of Medicine, Michigan State University, East Lansing

Histamine 2 receptor antagonists (H2RA) are one of the most widely prescribed classes of medications. A retrospective case study was designed to evaluate intravenous (iv) H2RA use in a community hospital. The charts of 113 patients on iv H2RA therapy, 69 on a general medicine floor (flr) and 44 in an intensive care unit (icu) were reviewed. Three aspects were evaluated; 1) indication for use, 2) dosage based on creatinine clearance, 3) route of administration with cost analysis. Indications for use were: prophylaxis 58%, gastrointestinal bleed 18%, maintenance therapy 16%, active peptic ulcer 8%. Forty percent of patients had appropriate H2RA dosing based on creatinine clearance, 44% inappropriate dosing and 16% with insufficient data to calculate. A total incremental cost of iv doses given after enteral medications were begun (cost of iv doses - cost of po doses = additional cost of drug) was \$1610/month on the flr and \$205/month in the icu. Our conclusions are: 1) Prophylactic dosing is most common use of iv H2RA treatment in this study, 2) IV H2RA is often inappropriately administered based on patient's renal function, 3) Parenteral H2RA therapy is often used when enteral dosing may be appropriate, 4) Appropriate administration would save >\$20,000 annually in this medium-sized community hospital. It is our hope that with increased awareness of proper H2RA use we will see beneficial results for patient care and substantial financial savings.

9. Is The Sputum Gram Stain Useful in Guiding Antibiotic Therapy?

Richard Potts, DO; Diane MacDonald, MD, Department of Medicine, Michigan State University, East Lansing

The sputum gram stain is often used to guide initial antibiotic therapy in community acquired pneumonia, but recently its usefulness has been criticized. To evaluate the value of the sputum gram stain in directing initial antibiotic therapy, a retrospective chart review of patients with confirmed pneumonia was conducted in a community teaching hospital of 400 beds. Patients with a chest infiltrate on x-ray, symptoms of pneumonia, leukocytosis or fever and gram stained sputum were included in the study. Patients fulfilling these criteria were excluded if they were treated with antibiotics in the previous 30 days. Fifty-five patients were identified between July 1988-January 1989. The sputum gram stain result was classified as suggestive of an underlying organism if the specimen was Grade IV (purulent and few epithelial cells) or higher and a predominate organism was identified, or not suggestive if the specimen was less than Grade IV (minimally purulent and numerous epithelial cells) or a predominate organism could not be identified. The standard for appropriate antibiotic therapy was a consensus

decision of a panel of five Medicine faculty at MSU after reviewing reports of suggestive sputum specimens. Suggestive specimens comprised only 16% of the total sample. 10% of patients had a bacteremic pneumonia, but none of these patients had a suggestive sputum specimen. Of the patients with suggestive sputum sample, 78% were started on appropriate antibiotic therapy according to the expert panel. Using the sputum culture as the diagnostic "Gold Standard", the sensitivity and specificity of the sputum gram stain were 55% and 91% respectively. The positive and negative predictive values of a sputum gram stain were 75%, and 81% respectively. Using only suggestive gram stain specimens, the positive and negative predictive values increased to only 78% and 84% respectively. These results suggest that the sputum gram stain in this institution was infrequently suggestive of a potential respiratory pathogens, and while specificity is high, sensitivity may be unacceptably low for clinical utility.

10. Nosocomial Legionellosis in a Patient with Pneumococcal Pneumonia.

Steven N. Schroeder, MD and Lewis Rosenbaum, MD, William Beaumont Hospital, Royal Oak

Pneumonia remains a leading cause of morbidity and mortality especially in the elderly and immunosuppressed. The often confusing and overlapping clinical presentation of "typical" and "atypical" pneumonias makes the diagnosis difficult in the absence of specific cultures and/or tissue available for histopathology.

A 63 year old female with a remote history of pulmonary tuberculosis and right thoracoplasty presents with a two day history of shaking chills, right sided pleuritic chest pain, and diarrhea. Chest x-ray showed chronic bibasilar changes, right thoracoplasty and pleural effusion without evidence of consolidation. Treatment with erythromycin was begun. Blood cultures at 72 hours grew Strep, pneumonia and treatment was changed to penicillin (PCN). The patient's respiratory status deteriorated requiring mechanical ventilation. Repeat blood cultures were negative on four occasions. Routine sputum cultures grew Pseudomonas Aeruginosa. AFB stains were negative and no further studies were ordered. Of note was a new left upper lobe infiltrate on chest x-ray on day #21. Despite 10 days of therapy with PCN, the patient expired on day #25. At autopsy Legionella pneumophila serogroup 3 was grown from the left upper lobe. Histopathology, as well, demonstrated this organism by immunofluorescence.

Our report illustrates an unusual case, in which a patient with a history of pulmonary tuberculosis developed pneumococcal pneumonia, which was then complicated by a nosocomial legionella pneumonia. Review of the literature reveals at least two similar reports. Therefore, we suggest when a patient with a community acquired pneumonia deteriorates after appropriate treatment has been given for the latter, consideration should be given to the possibility of a nosocomial legionellosis.

11. Reappraisal of Radiation Therapy for Ameloblastoma.

Andrew W. Saxe, MD, FACS; W. Reynolds, MD; E. Beck, MD and H. Chang, MD, Sinai Hospital of Detroit and Henry Ford Hospital

Ameloblastomas are tumors of dental origin representing approximately 1% of head/tumors. They have been considered to be radio-



Clinical Poster Presentations continued

resistant tumors, however interest in the application of radiotherapy has re-emerged. This renewed interest has been fostered by advances in our understanding of radiation biology, better techniques in the delivery of radiation therapy, and alternate forms of therapy now available. Also, critical reviews of previously reported cases of ameloblastoma treated with radiation therapy are unable to define the radioresistant or radiosensitive nature of these tumors. Previous reports lack adequate histopathologic proof of ameloblastoma, adequate radiotherapeutic data, and adequate follow-up.

This poster will critically review the criteria for evaluating the effectiveness of radiotherapy for ameloblastoma as proposed by Gardner (1988) in light of modern concepts and techniques of radiotherapy. The poster will present alternative criteria.

12. Single Vessel Forebrain Perfusion.

John Lloyd Zinkel, MD, Department of Neurosurgery, Wayne State University, Detroit

In the rat, forebrain perfusion can be reduced to that by one internal carotid artery alone without injury. This is done by occluding the left external carotid, right internal carotid, the distal basilar, both pterygopalatine and both occipital arteries.

Total hemisphere ischemia is studied in the awake rat by reversible occlusion (with a loop) of the left common carotid artery. Partial ischemia is studied when catheters are placed retrograde into the left external carotid and left femoral arteries. The left common carotid is occluded and blood is pumped at a controlled rate from the femoral artery catheter through a perfusion pump and then into the hemispheres by way of the external carotid catheter.

To study closed head injury, the carotid loop is tightened in the awake rat. He slumps into decerebrate coma (a coma far deeper than can be caused with pharmacologic anesthesia without causing hemodynamic instability). The injury is introduced and the loop is loosened.

Sixty four rats are studied. Rats without superimposed brain injury (n=12) are neurologically and histologically normal. Histology is also normal for rats subjected to one minute total ischemia (n=8), to eight minutes total ischemia (n=8), to one minute total ischemia with a superimposed mild closed head injury (n=8, 80 lb. impulse) and for pump-controlled forebrain perfusion where the common carotid artery is not occluded. Significant histologic injury occurs when partial ischemia (n=8) is introduced at 0.25cc/min total forebrain flow for a total of 8 minutes.

Specific results will be demonstrated.

13. Staphylococcus Aureus Gangrenous Cholecystitis: A Unique Case of Iatrogenic Disease.

Brent VanHoozen, MD and C.M. Wu, MD, Department of Medicine, Michigan State University, East Lansing

Acute gangrenous cholecystitis secondary to *S. aureus* is a rare event. To date, there are only six cases reported in the English Medical literature, all complications of percutaneous transhepatic cholangiograms. Reported here is the first case of *S. aureus* gangrenous cholecystitis as the result of a cardiac catheterization or septic superficial thrombophlebitis. This novel case involves a previously healthy 49 year old man who underwent right and left ventricle catheterization as part of an evaluation for an episode of

substernal chest pain. The procedure was complicated by superficial thrombophlebitis at an IV access site and temperatures to 102°F. Despite this, the patient insisted upon his discharge, and this was granted with institution of cephalexin antibiotic therapy. Five days following the catheterization, the patient developed right upper quadrant tenderness, hepatomegaly, and a palpable mass 3 cm below the right costal margin. Initially, medical treatment was attempted but was followed in 48 hours with an emergency cholecystectomy for presumed cholecystitis. At surgery, a gangrenous, dilated gallbladder was removed. Multiple blood cultures were positive for *S. aureus* as was the bile and wall of the gangrenous gallbladder. His hospital course was further complicated by *S. aureus* endocarditis and pneumonia, and congestive heart failure. It is speculated that the patient's original chest pain investigated with coronary arteriography was an attack of cholelithiasis. The inflamed gallbladder became infected secondary to a *S. aureus* bacteremia from either an septic superficial thrombophlebitis or cardiac catheterization. This case is important for reminding physicians that simple as well as complex procedures can produce severe iatrogenic disease and it also clearly illustrates the potential lethality of *S. aureus* bacteremia.

14. Sudden Gynecomastia In A Patient Treated with Testosterone.

Martha Pollock, MD and Luis Ospina, MD, FACP, William Beaumont Hospital, Royal Oak

Gynecomastia is generally viewed as a disruption in the normal androgen/estrogen balance. Evaluation necessitates searching for the cause of increased estrogen or decreased androgen due to tumors, adrenal or liver disease, medications or other endocrinopathy. Even after extensive work-up, this condition is often judged idiopathic in nature.

A 32 year old white male with functional prepubertal castrate, diagnosed in 1975 had been well-maintained on self-administered testosterone enanthate (Delatestryl) 200mg IM every three weeks. In early July, 1989, he presented with increased breast size, tenderness and hardness developing over a 3 to 6 week period. LH and FSH were low, HCG was negative, prolactin and thyroid function studies were normal, and CEA was low. However, serum estradiol was 3,840 pg/mL (normal 10-60), and serum estrogen was 3,814 pg/mL (normal 40-115). No clinical explanation could be found for this patient's increased estrogen and gynecomastia. In late July, the patient mentioned that the testosterone he had been taking for several weeks was different from his previous testosterone. Upon review, it was determined that he had mistakenly been given Delestrogen (Estradiol Valerate) rather than the prescribed Delatestryl. Delestrogen was discontinued and Delatestryl restarted. By late July, serum estrogen was 919 pg/mL, in August, 489 pg/mL and, near normal 144 pg/mL in November 1989, with resolution of gynecomastia and local symptomatology.

We conclude that, in evaluating gynecomastia, the clinician must consider not only an underlying endocrinopathy, but also an inadvertent exogenous hormonal source. A careful drug history includes verification of medications, dosage, and administration with examination of each medication by the physician.



15. Use of Etidronate for Treatment of Refractory Immobilization Hypercalcemia in a Patient with Landry-Guillain-Barre Syndrome.

Ved V. Gossain, MD; C.M. Wu, MD; Brent VanHoozen, MD and David R. Rovner, MD, Michigan State University, East Lansing

Immobilization hypercalcemia due to Landry-Guillain Barre Syndrome (LGBS) has rarely been reported. We report a patient with LGBS who developed marked hypercalcemia due to immobilization. Hypercalcemia was refractory to treatment with I.V. fluids, furosemide and calcitonin, but responded promptly to Etidronate. A 40 year old, white male was hospitalized with a diagnosis of LGBS. He developed quadriplegia and acute respiratory failure requiring chronic ventilatory therapy for six months. Serum calcium level on admission was 7.3 mg/dl. After three months of immobilization, calcium level increased to 11.8 mg/dl. Despite I.V. saline, furosemide and calcitonin therapy, calcium levels increased to 13.1 mg/dl. Etidronate was then added to the therapeutic regimen resulting in marked decrease in serum calcium level to 10.9 mg/dl. Two weeks later serum calcium again increased to 12 mg/dl. A second course of etidronate was given which normalized the calcium level for the remaining part of his hospitalization. Etidronate lowers serum calcium by reducing bone resorption. It has been frequently used in the treatment of hypercalcemia due to malignancy, but has not been widely used in immobilization hypercalcemia. Etidronate therapy should, therefore, be considered in the treatment of refractory hypercalcemia due to immobilization.

16. Compartment Syndrome After Low-Velocity Gunshot to the Forearm.

Anton J. Fakhouri, MD, Department of Orthopaedic Surgery, Wayne State University

A retrospective study was undertaken to evaluate the potential for compartment syndrome and possible risk factors following low-velocity gunshot wounds to the forearm. The medical records and radiographs of all patients treated for gunshot wounds to the forearm from 1980 to 1988 were reviewed. One hundred and thirty-one forearms in 127 patients were identified as having sustained a low-velocity gunshot wound. Gunshot wounds resulted in a fracture in 60 of the forearms, while 71 were without a fracture. The fractures were located in the proximal one-third of the forearm in 22, the middle one-third in 20, and distal one-third in 18. The diagnosis of compartment syndrome was based on tissue pressure measurements and/or clinical examination. A univariate analysis followed by a multivariate stepwise logistic regression was used to evaluate potential risk factors including fracture location, displacement,

comminution and the radiographically determined quantity of retained metallic fragments. A compartment syndrome was diagnosed in 13 of the extremities (10%). While a compartment syndrome occurred in four of the non-fracture patients (6%), one of the distal third fracture group (6%), and none of the middle third fracture group, eight of the 22 limbs with a proximal gunshot fracture (36%) were complicated by the occurrence of a compartment syndrome. Fracture location was the only significant risk factor for the development of a compartment syndrome ($p < 0.005$). Low-velocity gunshot injuries to the forearm are at a significant risk for the occurrence of compartment syndrome. A high index of suspicion is necessary to prevent untoward sequelae. Patients with this injury, especially those with a proximal one-third fracture who constitute an extremely high risk group, should be monitored closely.

17. Compartment Syndrome After High-Energy Injury to the Foot

Anton J. Fakhouri, MD and Arthur Manoli, II, MD, Department of Orthopaedics, Wayne State University

A retrospective study was undertaken to evaluate the occurrence of compartment syndrome of the foot and the various methods of foot fasciotomy. Twelve cases of compartment syndrome of the foot in ten patients were diagnosed between 1986 and 1988. All of the injuries were described as high-energy, sustained in a fall (six), crush (three) or motor vehicle accident (three). Bony injuries of the foot included five calcaneal fractures, three multiple metatarsal and/or phalangeal fractures and two Lisfranc fracture-dislocations with multiple metatarsal neck fractures. Two patients did not have fractures of the foot. Compartment syndromes of the foot and ipsilateral leg developed concomitantly in three patients. The diagnosis of compartment syndrome was made by clinical examination and tissue pressure measurements. Two patients sustained a closed head injury. The eight conscious patients complained of severe pain of the foot, four complained of tingling and numbness, five had sensory deficits in the foot and five had pain with passive motion of the toes. The most consistent physical finding was tense swelling of the foot found in all twelve cases. Compartment syndrome was confirmed by intracompartmental pressure measurements in all the feet. Decompressive fasciotomies were performed by the medial approach of Henry in six feet, combined medial and dorsal incisions in four and combined, medial, dorsal and lateral incisions in two. All of these approaches were effective in decompressing the foot. Follow-up evaluations at one to two years revealed no sequelae of compartment syndrome we conclude that high-energy injuries are at definite risk for the development of compartment syndrome of the foot. A high index of suspicion is necessary for the diagnosis. A fasciotomy can be adequately performed by the above methods, although the combined medial and dorsal approach is probably the safest and easiest.





Great Lakes Exhibit Center

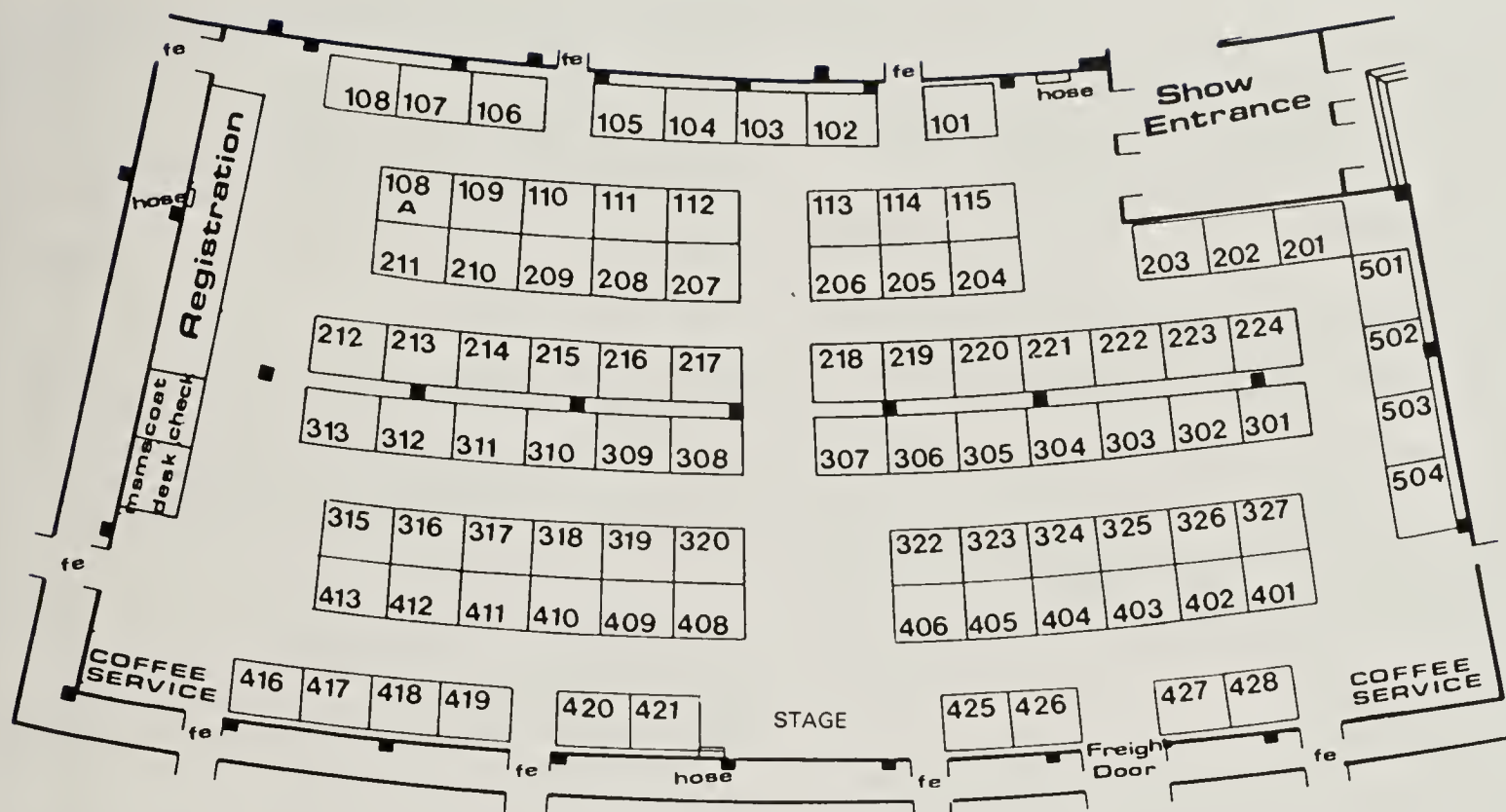


Exhibit Information

Exhibit Hours:

Tuesday.....	7:30 am - 5:30 pm
Wednesday.....	7:30 am - 5:30 pm
Thursday.....	7:30 am - 5:00 pm

Coffee:

Tuesday.....	7:30 am - 4:30 pm
Wednesday.....	7:30 am - 4:30 pm
Thursday.....	7:30 am - 4:00 pm

Poster Presentations:

Tuesday.....	8:30 am - 5:30 pm
Wednesday.....	8:30 am - 5:30 pm

Dessert/Activities

All Three Days.....	12:30 pm - 1:30 pm
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* A Deli Lunch will be held from 11:45 am - 1:00 pm in the Hubbard Ballroom on all three days.

Refreshments

Tuesday.....	4:30 pm - 5:30 pm
Wednesday.....	4:30 pm - 5:30 pm

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Advance Medical/Metpath Booth 401 4444 Giddings Road Pontiac, MI 48055 Valuable information for the clinician on the latest in clinical laboratory testing services. Information also available for those offices doing laboratory testing in-house. Regulations, proficiency surveys, quality control, seminars and laboratory consultations.	Boehringer Ingelheim Booth 206 2662 Browning Drive Lake Orion, MI 48035 Product line we will display will be: Atrovent; TTS; Mexitic; Buspar; Alupent; and Activasp
Ameritech Mobile Communications Booth 214 32255 Northwestern Highway, Suite 143 Farmington Hills, MI 48334 Learn about the benefits and applications of mobile communications to the health care industry, provided by Ameritech Mobile Communications and its 5 Star Dealer, Metro Cell. Mobile phones, FAX, and data communications applications exhibited.	Cellular One Booth 106 31500 Northwestern #300 Farmington Hills, MI 48018
Bell Atlantic Tricon Leasing Medical Finance Division Booth 110 6565 West Loop South, Suite 120 Bellaire, TX 77401 MSMS endorsed medical equipment leasing program provides financing/leasing for any medical, surgical, office or computer equipment used in a medical practice.	Colonial Valley Software Booth 419 3398 South Dye Flint, MI 48507 Colonial Valley Software (CVS) markets a complete turnkey computer system that is superior because of its telecommunications for faster payments, patient recall ability, excellent support, easy to use, and complete financial reporting. It is the discriminating doctor's choice.
Bennethum Computer Systems Booth 211 7125 Orchard Lake Road, Suite 310 West Bloomfield, MI 48322 In existence since 1968, Bennethum Computer is one of the oldest Michigan medical computer companies. Since we offer three different programs for medical offices we are able to meet any desired degree of sophistication in any price range.	Comerica Bank Booth 113 211 W. Fort Street Detroit, MI 48275-1173 Comerica offers high quality personal and professional financial services to meet your financial needs. Your relationship manager will draw upon the resources of a \$12 billion financial institution to serve your borrowing or investment needs.
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Blue Cross/Blue Shield of MI Field Services Booth 426 600 Lafayette East Detroit, MI 48226 The Blue Cross and Blue Shield of Michigan Field Services exhibit is staffed with Consultants ready to answer your questions on the New Physician Agreement as well as billing and policy questions.	Dar-Ware, Inc. Booth 323 8323 Office Park Drive Grand Blanc, MI 48439 Dar-Ware, Inc. is featuring the DAR-MED Medical Practice Management System. DAR-MED was designed by Dr. E.J. Daros for streamlining his busy practice. DAR-MED's simplicity and flexibility make it a must see for any practice considering automation.
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	Disability Determination Services Booth 418 P.O. Box 30011 DDS Lansing, MI 48909 This exhibit is for the purpose of acquainting physicians with the Social Security Disability Program. We will dispense pertinent handouts which will be helpful in evaluation of disabled patients who may meet governmental requirements for disability benefits.



Exhibitors continued

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DuPont Pharmaceuticals will exhibit: Ethomozine® a new anti-arrhythmic drug for documented ventricular arrhythmias which are life threatening. Coumadin® - 1 mg. dosage for titrating low intensity anticoagulation. Hespan® - Blood volume replacement therapy.
- Encyclopedia Britannica, USA Booth 217**
210 S. Michigan Avenue
Chicago, IL 60604
- The Equitable Association Booth 102**
Members Retirement Programs
200 Plaza Drive
Secaucus, NJ 07096
- Firestone X-Ray Corporation Booth 301**
1890 Starbatt Drive
Rochester Hills, MI 48209-3709
Service 24 hours a day, 7 days a week; X-Ray equipment sales and service; Processor sales and service; Suppliers of Agfa, Kodak and Dupont film and chemicals; Dealer for Wolf, S & S, Spectronics, Liebel-Flarsheim, BarRay, Iatrics, C.F.I. and E-Z-EM Barium products; Complete silver recovery systems; Lead lining of x-ray rooms. We buy used film.
- Fisons Pharmaceuticals Booth 207**
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Please stop by booth #207 as Fisons Pharmaceuticals present the Intal® Patient Prescription Pledge program for aiding physicians in treating and educating patients with asthma.
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c/o P.O. Box 9088
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Allen & Hanburys
Division of Glaxo Inc.
Five Moore Drive
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Pharmaceuticals used in the treatment of acid/peptic disorders, hypertension, bronchospastic diseases, allergic rhinitis and infectious diseases.
- Henry Ford Health System Booth 223**
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Henry Ford Continuing Care's two nursing homes offer quality nursing care including a specialized program devoted to Alzheimer patients. Henry Ford Rehabilitation features specialty services through Henry Ford's Speech Pathology programs, comprehensive inpatient rehabilitation programs, cardiopulmonary, return-to-work, sports medicine and traumatic brain injury rehabilitation.
- Henry Ford Health System Booth 202**
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Henry Ford Hospital and Medical Centers is in the forefront of research and clinical developments in a variety of specialties, including dermatology, special procedures, organ transplantation and reproductive endocrinology and infertility.
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Kingswood Hospital
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Kingswood Hospital is a leader in short-term, acute inpatient psychiatric care. In addition to adolescent and adult services, it offers urgent psychiatric evaluation on an outpatient basis and an adolescent dual diagnosis program.
- Henry Ford Health System Booth 201**
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CONSULT LINE - The 24-hour, toll-free service offered to physicians, hospital, agencies, other health care professionals. Physicians can consult with Henry Ford senior staff physicians, schedule appointments, make referrals, obtain CME information, transfer and transport patients.
- Henry Ford Health System Booths 501 & 502**
Wyandotte Hospital and Medical Center
2333 Biddle Avenue
Wyandotte, MI 48192
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- Henry Ford Medical Group Booth 222**
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Detroit, MI 48202
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444 East Highway 96
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A full service collection agency endorsed by Physicians Service Group to all members of the Michigan State Medical Society. All collection efforts are legal, ethical and as comprehensive as you want them to be.
- Janssen Pharmaceutica Booth 412**
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Medical Automation, Inc. Booth 315
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Metric Medical Labs Booth 109
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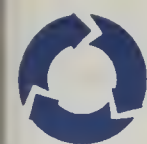
Michigan Physicians Mutual Liability Company Booth 108
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East Lansing, MI 48823-1563
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PICOM is a Michigan based, physician owned medical malpractice insurer serving individual and group practices throughout Michigan. Deductible credits, merit rating and million dollar coverage available.

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Smith Kline Beecham Booth 408

PO Box 7929, E-22
Philadelphia, PA 19101

Representatives will be on hand to answer you specific questions and to provide information on our products and services.

E.R. Squibb & Sons, Inc. Booth 308

PO Box 4500
Princeton, NJ 08543

E.R. Squibb & Sons, Inc. has long been a leader in the development of therapeutic and diagnostic products for the prevention, detection and treatment of diseases. You are cordially invited to meet our representatives who will be available at our exhibit to discuss our full line of health care products.

Stratton Cheeseman & Associates Booth 203

1400 Abbott Road, Suite 330
East Lansing, MI 48823

Stratton-Cheeseman & Associates features group disability, business overhead and life insurance for MSMS members. Information is available, too, on other personal and commercial coverages such as home, auto, building/contents, Workers' Compensation and ERISA bonds.



Exhibitors continued

Summit Pharmaceuticals Booth 405
500 Northridge Road, Suite 780
Dunwoody, GA 30350

Target Equipment Leasing, Inc. Booth 302
30555 Southfield, Suite 140
Southfield, MI 48076

University of Michigan Department of Booth 213
Neurology
300 N. Ingalls, Rm 4C01, Box 0475
Ann Arbor, MI 48109
Two new programs are highlighted: The Michigan Alzheimer's Disease Research Center, one of fifteen NIH-funded centers, and the Epilepsy Surgery Program, providing an alternative treatment for patients with seizures not responding to medical therapy.

University of Michigan Booth 212
Medical Center: M-Line
300 N. Ingalls, Rm 4C01, Box 0475
Toll-free communication service for physician-to-physician consultation and referral. Direct access for referring physicians to the faculty and services of the University of Michigan Medical Center.

U.S. Army Medical Department Booth 413
5111 Leesburg Pike, Suite 638
Falls Church, VA 22041-3258

Upjohn Healthcare Services Booth 309
2387 S. Linder Road
Flint, MI 48532
Upjohn has been a leading provider of home health care for more than 20 years. We provide health care professionals from companions to nurse specialists, as well as many specialized services your clients may require.

Wyeth-Ayerst Laboratories Booth 421
PO Box 2064
Saginaw, MI 48605
Please visit the Wyeth-Ayerst Laboratories exhibit and our representatives will be happy to discuss Premarin, Triphasil, Verelan and Orudis.

The Michigan State Medical Society is pleased to provide space at the Annual Scientific Meeting for the exhibitions. The Society does not thereby endorse or recommend the service and products of the exhibitors or in any way pass upon their merits.

Index to Exhibitors

Booth

- 101 Physician Service Group, Inc.
- 102 The Equitable/Association Members Retirement Programs
- 103 Medical Billing Services
- 104 Medical Billing Services
- 105 A.H. Robins Company
- 106 Cellular One
- 107 Medical Software Solutions, Inc.
- 108 Michigan Physicians Mutual Liability Company
- 108A Accent Leasing, Inc.
- 109 Metric Medical Labs
- 110 Bell Atlantic Tricon Leasing
- 111 Physicians Insurance Company of Michigan
- 112 Metro Rehabilitation Services, Inc.
- 113 Comerica Bank
- 114 Randolph Medical Inc.
- 115 I.C. System, Inc.
- 201 Henry Ford Health System/Referring Physician Office
- 202 Henry Ford Health System/Henry Ford Hospital and Medical Centers
- 203 Stratton Cheeseman & Associates
- 204 Professional On-Line Computer, Inc.
- 205 Pfizer Laboratories
- 206 Boehringer Ingelheim
- 207 Fisons Pharmaceuticals
- 208 Russ Pharmaceuticals, Inc.
- 209 Blue Cross Blue Shield of MI/Automated Billing Concepts
- 210 Professional Practice Sales, Inc.
- 211 Bennethum Computer Systems
- 212 University of MI Medical Center/M-Line
- 213 University of MI/Department of Neurology
- 214 Ameritech Mobile Communications
- 215 Michigan Bell
- 216 Michigan Bell
- 217 Encyclopedia Britannica, USA
- 218 Prudential-Bache Securities
- 219 Blue Cross Blue Shield of MI/Professional Provider Systems
- 220 Davis-Smith Medical-Dental Employment Service, Inc.
- 221 Retirement Plan Consulting Group/ Shearson Lehman Brothers, Inc.
- 222 Henry Ford Medical Group/Physician Recruitment
- 223 Henry Ford Health System/Henry Ford Continuing Care Corporation and Henry Ford Rehabilitation
- 224 Henry Ford Health System/Kingswood Hospital

Booth

- 301 Firestone X-Ray Corporation
- 302 Target Equipment Leasing Inc.
- 305 Select Communications
- 306 Miles Inc., Pharmaceutical Division
- 307 Michigan Headpain and Neurological Institute
- 308 E.R. Squibb & Sons, Inc.
- 309 Upjohn Healthcare Services
- 312 Medsys
- 313 Continental Bio-Clinical Laboratory Service, Inc.
- 315 Medical Automation, Inc.
- 316 Preferred Laboratories
- 317 Geigy Pharmaceuticals
- 320 Mead Johnson Pharmaceuticals
- 322 P.C. Medical Mgmt. Inc./Detroit Bio-Medical Lab
- 323 Dar-Ware Inc.
- 326 Beyond Business Techonology, Inc.
- 327 Merck Sharp & Dohme
- 401 Advance Medical/Metpath
- 404 Perry ComfortCare
- 405 Summit Pharmaceuticals
- 406 Medical Computer Consultants, Inc.
- 408 Smith Kline Beecham
- 409 Merck Sharp & Dohme
- 411 National Health Laboratories
- 412 Janssen Pharmaceutica
- 413 U.S. Army Medical Department
- 416 Parke-Davis
- 417 Key Pharmaceuticals
- 418 Disability Determination Services
- 419 Colonial Valley Software
- 420 Professional Asset Management
- 421 Wyeth-Ayerst Laboratories
- 425 DuPont Pharmaceuticals
- 426 Blue Cross Blue Shield of MI/Field Services
- 427 Management Systems Engineering, Inc.
- 428 McNeil Consumer Products Company
- 501 Henry Ford Health System/Wyandotte Hospital and Medical Center
- 502 Henry Ford Health System/Wyandotte Hospital and Medical Center
- 503 Damon Clinical Laboratories
- 504 Glaxo Pharmaceuticals and Allen & Hanburys/Division of Glaxo, Inc.



Schedule of Special Events

Clinical Poster Displays

Tuesday and Wednesday, November 6-7 (all day)
Regency Ballroom Corridor

"Early Bird" Plenary Sessions I and II

Wednesday, November 7 at 7:00 am
Thursday, November 8 at 7:00 am
Hubbard Ballroom (Coffee and Rolls included)

MSMS ASM Planning Committee Reception

Tuesday, November 6 at 6:00 pm
Pierce Arrow Suite (2nd floor)
Contact: Ms. Sherry Fent, MSMS

MSMS Committee on Concerns of Women Physicians

Wednesday, November 7
Luncheon at 12:00 noon
Rolls Royce Suite (2nd floor)
Contact: Ms. Lori Randall, MSMS

MSMS Committee of Specialty Society Presidents

Wednesday, November 7
Luncheon at 12:00 noon
Franklin Room (2nd floor)
Contact: Mr. David Fox, MSMS

MSMS Physician Service Group, Inc.

Wednesday, November 7
Reception/Dinner at 6:30 pm
Dearborn Inn, Firestone Room
Contact: Ms. Amy Fistler

Michigan Academy of Plastic Surgeons

Thursday, November 8
Reception /Dinner at 6:00 pm
Pierce Arrow Suite (2nd floor)
Contact: Donald Ditmars, Jr., MD

Michigan Allergy Society

Wednesday, November 7
Board Meeting at 9:00 am
Model T Room (2nd floor)
Contact: Vi Heins, MSMS

Michigan College of Nuclear Medicine Physicians

Thursday, November 8
Reception/Dinner/Meeting at 6:00 pm
Atlanta/Chicago, Regency Ballroom
Contact: Richard Wetzel, MD

Michigan Occupational Medical Association

Wednesday, November 7
Executive Board Meeting/Lunch at 12:00 noon
Thomas Room (2nd floor)
Reception/Dinner at 6:00 pm
Houston/San Francisco, Regency Ballroom
Contact: Martin L. Charles, MD

Michigan Orthopaedic Society

Wednesday, November 7
Board Meeting at 3:00 pm
Franklin Room (2nd floor)
Reception/Dinner/Program at 6:30 pm
Atlanta/Chicago, Regency Ballroom
Contact: Ms. Joanne Sackett

Michigan Physicians Mutual Liability Company

Wednesday, November 7
Board Meeting at 12:00 Noon
Contact: Ms. Sandy Gould

Michigan Society of Anesthesiologists

Wednesday, November 7
Meeting at 5:15 pm
Stanley Steamer Suite (2nd floor)
Contact: Ms. Caroline Kimmel

Michigan Society of Colon & Rectal Surgeons

Wednesday, November 7
Reception Dinner at 6:30 pm
Stutz Bearcat Suite (1st floor)
Contact: Ms. Irene Babcock

Michigan State University College of Human Medicine

Alumni Association
Wednesday, November 7
Reception at 6:00 pm
Pierce Arrow Suite (2nd floor)
Contact: Ms. Dedria Barker

Please check Hyatt daily events monitor, as room assignments may change.



Index to Course Directors and Instructors

Page Name

18 Susan H. Adelman, MD, Southfield
19 Joshua Adler, MD, Detroit
16 Gaylord D. Alexander, MD, Detroit
9 Patrick C. Alguire, MD, East Lansing
18 James I. Ausman, MD, Detroit
15 Shirley Bach, PhD, Kalamazoo
6,11,18 Greg Baker, Portland
10 John V. Baugh, MD, Detroit
17 William L. Beauregard, MD, Royal Oak
13 James E. Blessman, Jr., MD, Detroit
23 Dennis I. Bojrab, MD, Royal Oak
7,14 Chaim M. Brickman, MD, Detroit
6 Henry Brystowski, MD, Birmingham
8 JoAnn V. Bush, OT, Detroit
8 Hugh Calkins, MD, Ann Arbor
22 Oliver G. Cameron, MD, Ann Arbor
18 Burton D. Cardwell, PhD, Lansing
14 James Carpenter, MD, Ann Arbor
16 Thomas A. Chapel, MD, Dearborn
16 Martin L. Charles, MD, Livonia
19 Mark Chimowitz, MD, Ann Arbor
6 Nishit Choksi, MD, Royal Oak
7 C. W. Christensen, MD, Detroit
10 Flossie Cohen, MD, Detroit
20 Marcus Collares, MD, Southfield
16 Daniel Connor, MD, Chevy Chase
12 Arnold G. Coran, MD, Ann Arbor
6,11,18 Gwen Cowan, RN, Lansing
21 Charles P. Craig, MD, Ann Arbor
21 Lawrence R. Crane, MD, Detroit
19 Paul A. Cullis, MD, Troy
16 Frederick N. Davis, MD, Grand Rapids
8 Michael de Buitleir, MD, Ann Arbor
6,12,18 Debra Deford, RN, Lansing
12 Raymond Y. Demers, MD, Detroit
16 Michael de Rosayro, MD, Ann Arbor
7 Gunter Deppe, MD, Detroit
21 Angela DeSantis, MD, Dearborn
19,20 Donald M. Ditmars, MD, Detroit
19,20 Charles J. Eaton, MD, Salt Lake City, UT
21 Jack Ebright, MD, Detroit
10 Robert D. Eden, MD, Detroit
22 Murray N. Ehrinpreis, MD, Detroit
17 Thomas A. Fox, MD, Detroit
13 Alfred Franzblau, MD, Ann Arbor
12 John E. Freitas, MD, Royal Oak
20 Keizo Fukuta, MD, Southfield
7 Martha Funnell, RN, Ann Arbor
20 Stephen S. Gebarski, MD, Ann Arbor
19 Steve R. Geiringer, MD, Ann Arbor
7 Jose' Goldman, MD, Detroit
22 Pamela Gordon, MD, Detroit
16 Mark L. Gostine, MD, Grand Rapids
20 Mune Gowda, MD, Southfield
14 Martha L. Gray, MD, Ann Arbor
22 John F. Greden, MD, Ann Arbor
15 Eugene C. Grochowski, MD, Kalamazoo
12 Milton Gross, MD, Ann Arbor
22 Leon Grunhaus, MD, Ann Arbor
10 Alan B. Gruskin, MD, Detroit
17 Gabriel P. Haas, MD, Detroit
17 Peter A. Haas, MD, Detroit
20 Yaron Har-Shai, MD, Southfield
15 John V. Hartline, MD, Kalamazoo
11 Houria I. Hassouna, MD, East Lansing
15 Richard L. Hatton, MD, Okemos

Page Name

15 Marilyn Haupt, MD, Detroit
9 Daniel Havlichek, MD, East Lansing
20 David B. Hawtof, MD, Southfield
21 Paul Haydon, MD, Dearborn
8 Craig Hillemeier, MD, Ann Arbor
20 Herman P. Houin, MD, Detroit
18 Vernon Houk, MD, Atlanta, GA
16 Hal Humphrey, PhD, Lansing
6 Samuel D. Indenbaum, MD, Birmingham
21 Deborah Iverson, MD, Detroit
20 Peter K. Janevski, MD, Detroit
22 Sidika E. Kasim, MD, Detroit
7 Donald B. Kaufman, MD, East Lansing
9 Honorable John Kirkendall, Ann Arbor
17 Steven N. Klein, MD, Southfield
14 D'Anne Kleinsmith, MD, West Bloomfield
10 George A. Kling, MD, Detroit
14 Cassandra M. Klyman, MD, Bloomfield Hills
17 Stephen Knazik, DO, Detroit
13,15 James Kruse, MD, Detroit
13 Gloria J. Kuhn, DO, Detroit
13 Alvin E. Lake, III, PhD, Ann Arbor
8 Fred K. Lamb, MD, Detroit
6,12,18 Laura Lane, RN, Lansing
14 David M. Lang, MD, Detroit
14 Carl B. Lauter, MD, Royal Oak
10 Hugh Y. Lee, MD, Detroit
9 Daniel E. Leb, MD, Bloomfield Hills
6 James C. Leisen, MD, Detroit
21 Nicholas J. Lekas, MD, Dearborn
17 Herbert Lepor, MD, Milwaukee, WI
6 Robert N. Levin, MD, Royal Oak
6 T. Barry Levine, MD, Detroit
9 Joseph Lewis, MD, Detroit
19 Peter A. LeWitt, MD, Detroit
17 Mary Lieh-Lai, MD, Detroit
16 Todd E. Lininger, MD, Detroit
19 Robert P. Lisak, MD, Detroit
20 Adrian Lo, MD, Southfield
17 Martin Luchtefeld, MD, Grand Rapids
7 John J. Malone, MD, Detroit
7 Vinay K. Malviya, MD, Detroit
9 Federico G. Mariona, MD, Dearborn
18 Lynelle Marolf, Lansing
20 Frederick M. Maynard, MD, Ann Arbor
7 Joseph McCune, MD, Ann Arbor
21 Nancy M. McGuire, MD, Detroit
6 Mark McQuillan, MD, Ann Arbor
12 Donald A. Meier, MD, West Bloomfield
10 Curtiz D. Meriwether, MD, Detroit
14 Russell W. Miller, Ann Arbor
7 Allan H. Morton, DO, Warren
22 Marriyam Moten, MD, Allen Park
22 Milton Mutchnick, MD, Detroit
19 Julie Nagel, Ann Arbor
11 John O'Brien-Bell, MD, Surrey, BC
14 Gerald A. O'Connor, MD, Ann Arbor
8 Hope O'Leary, Ann Arbor
13 J. Ronald Oehler, MD, Ann Arbor
12 Keith T. Oldham, MD, Ann Arbor
7 Allan Olson, MD, Ann Arbor
6,11,18 Robert K. Orr, DO, Lansing
10 Enrique M. Ostrea, MD, Detroit
13,15,18 .. B. Babu Paidipaty, MD, Livonia
22 Atul C. Pande, MD, Ann Arbor

Page Name

20 Stephen M. Papadopolous, MD, Ann Arbor
14 Lawrence Pasik, MD, West Bloomfield
16 Blake Patterson, MD, Ann Arbor
23 Rene R. Peleman, MD, Detroit
11 John A. Penner, MD, East Lansing
17 J. Edson Pontes, MD, Detroit
12 Theodore Z. Polley, MD, Ann Arbor
15 John Popovich, MD, Detroit
17 Isaac J. Powell, MD, Detroit
15 Vinod K. Puri, MD, Southfield
17 Claude Reitelman, MD, Detroit
16 O.G. Rodman, MD, Farmington Hills
20 Jorge L. Rodriguez, MD, Ann Arbor
17 Norman Rosenberg, DO, Detroit
13 Kenneth D. Rosenman, MD, East Lansing
20 Jay Ross, MD, Southfield
10 Myer Roszler, MD, Detroit
18 Kenneth Rowe, MD, Hancock
16 Timothy Rutter, MD, Ann Arbor
13 Joel R. Saper, MD, Ann Arbor
17 Ashok P. Sarnaik, MD, Detroit
10 Howard Schubiner, MD, Detroit
21 Paula Schuman, MD, Detroit
11 Kenneth C. Schwartz, MD, East Lansing
6,12,18 Debra Seder, RN, Saginaw
10 Mark C. Segel, MD, Detroit
11 Gerald A. Shiener, MD, Detroit
9 Allen Silbergleit, MD, Pontiac
22 Ann Silverman, MD, Detroit
17 James B. Smith, Jr., MD, Detroit
9 Robert C. Smith, MD, East Lansing
21 Scott Sneed, MD, Ann Arbor
13 Anthony C. Southall, MD, Detroit
19 Peter Sparling, Ann Arbor
21 Alan Spigelman, MD, Southfield
19 D. Larry Stephenson, MD, Detroit
16 Georgine M. Steude, MD, Ann Arbor
23 Charles Stockwell, PhD, Royal Oak
14 Joan C. Stryker, MD, Detroit
8 Anna M. Szczotka, PT, Detroit
17 Eric J. Szilagyi, MD, Detroit
12 Gary B. Talpos, MD, Detroit
22 Rajiv Tandon, MD, Ann Arbor
8 Shirley Terry, RN, Detroit
9 Robert J. Toteff, MD, Troy
10 Atilla Turgay, MD, Detroit
9 Hollis Turnham, Lansing
16,18 Mark J. Upfal, MD, Detroit
9 Manuel Valdivieso, MD, Detroit
21 Lyle D. Victor, MD, Dearborn
7 Aaron Vinik, MD, Norfolk, VA
13 Bradford L. Walters, MD, West Bloomfield
6 Joseph J. Weiss, MD, Livonia
12 John R. Wesley, MD, Ann Arbor
10 Burt T. Weyhing, MD, Detroit
21 George Williams, MD, Royal Oak
18 Raj M. Wiener, MD, Lansing
10 Harvey I. Wilner, MD, Detroit
14 Edward M. Wojtys, MD, Ann Arbor
19 Joshua Wynne, MD, Detroit
10 Alkis P. Zingas, MD, Detroit



Cooperating Specialty Societies, Sections, Medical School Departments and Hospitals

American Diabetes Association, Michigan Affiliate
American Heart Association of Michigan
EAR Consultants of Michigan
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgeons
Michigan Allergy Society
Michigan Chapter, American College of Emergency Physicians
Michigan Chapter, American College of Surgeons
Michigan Chapter, Lupus Foundation of America
Michigan Dermatological Society Michigan Section,
American College of Obstetricians and Gynecologists
Michigan Head Pain and Neurological Institute
Michigan Occupational Medical Association
Michigan Ophthalmological Society
Michigan Rheumatism Society
Michigan Society of Anesthesiologists
Michigan Society of Colon and Rectal Surgeons
Michigan Society of Critical Care Medicine
Michigan Thyroid Association
Michigan Urological Society
MSMS AIDS Provider Education Project
MSMS Committee on Aging
MSMS Committee on Bioethics
MSMS Committee on Concerns of Women Physicians
MSMS Liaison Committee with Michigan Department of
Public Health
MSMS Task Force on Environment and Health

Michigan State University College of Human Medicine

Department of Internal Medicine
Department of Medicine

University of Michigan Medical School

Department of Anesthesiology
Department of Neurosurgery
Department of Psychiatry
Department of Internal Medicine
Department of Pediatric Surgery
Division of Pediatric Gastroenterology

Wayne State University School of Medicine

Department of Medicine
Department of Neurology
Department of Pediatrics
Department of Physical Medicine and Rehabilitation
Department of Psychiatry
Department of Radiology
Department of Urology

Hospitals

C. S. Mott Children's Hospital
Division of Pediatric Gastroenterology
Children's Hospital of Michigan
Department of Critical Care Medicine
Henry Ford Hospital
Hutzel Hospital
Department of Obstetrics and Gynecology
Oakwood Hospital Department of Medical Education
Rehabilitation Institute
St. Lawrence Hospital
St. Mary Hospital
William Beaumont Hospital
Department of Nuclear Medicine



Special Thanks

MSMS thanks Eli Lilly and Company for its financial support.



Restaurants

Average cost per meal:

\$ Under 9 Dollars

\$\$ 9 to 15 dollars

\$\$\$ Over 15 Dollars

Dining "in" at the Hyatt

A full range of dining options are available without ever leaving the Hyatt.

Kafay's Place

If you're looking for something on the lighter side, try Kafay's Place, featuring soups, salads and sandwiches all day long. For dinner the menu expands to include Mexican specialties. Open from 6:30 a.m. until midnight. \$

Giulio and Sons

The market atmosphere of Giulio and Sons features Italian American dishes including veal and chicken specialties. There also is a large salad bar with homemade pasta and a wide variety of meats. Sweet shop included. Lunch is served daily from 11:00 a.m. until 2:30 p.m. and dinner is from 6:00 p.m. until 10:30 p.m. \$\$\$

The Sushiiwa Hyatt

For something a little more adventuresome, the Sushiiwa Hyatt is a good place to start. Authentic Japanese Cuisine is its forte. Shabu-shabu (Japanese beef fondue) heads up the list of traditional favorites and for the dedicated aficionado of Japanese food there is a sushi bar. Open for lunch 11:00 a.m. to 2:30 p.m. and dinner 6:00 p.m. to 10:30 p.m. \$\$

The La Rotisserie

More formal dining can be found at the La Rotisserie. Fresh cut flowers, china and candlelight create a luxurious atmosphere for an evening meal. The dining room opens at 6:00 p.m. The La Rotisserie features a full continental menu. \$\$\$

Eating "out" in the Dearborn area

If you need to get out after a long day, you might consider trying one of the Dearborn area's fine or unusual restaurants.

Fairlane Charley's

700 Town Center Drive

336-8550

For those who don't want to wander far from the ASM, Fairlane Charley's is only a few steps away in the Fairlane Town Center. Charley's is open for lunch 11:00 a.m. to 4:00 p.m. with soups, salads and sandwiches. Dinner, served 4:00 p.m. until midnight, features a fresh seafood catch, beef and chicken entrees. \$\$

The American Bar and Grille

17000 Hubbard Drive

271-4020

The American Bar and Grille features regional American atmosphere and food. The American Bar specializes in grilled seafood, chicken, and beef. A wide variety of sandwiches also are available. Open weekdays 11:00 a.m. until midnight. \$\$

The Peacock Restaurant

4045 Maple

582-2344

The Peacock Restaurant is a good stop for the truly unusual. Cuisine direct from India is the fare. The Peacock is proud of its curries and vegetables dishes. Delicious breads like papadams, chapatis, and pooris (deep fried puff balls) also are a specialty. Dining hours are 11:00 a.m. until 2:30 p.m. for lunch and 5:30 p.m. until 10:30 p.m. for dinner. \$\$

The Chambertin

22900 Michigan Avenue

278-4800

More elegant dining may be found nearby at the Chambertin, located in the Dearborn Holiday Inn. The Chambertin features beef and lamb entrees. An elegant lunch is served from 11:00 a.m. until 2:00 a.m. Dinner is served from 5:00 p.m. until 1:00 a.m. \$\$\$

Silky Sullivan's/Kiernan's Steak House

21931 Michigan Avenue

565-4260

A favorite for 25 years. Unusual mix of elegant and casual cuisine can be found at these adjoining restaurants, especially at Silky's. Open 11:00 a.m. to 2:00 a.m., the steakhouse offers less expensive fare. \$\$

The Beirut Gardens

13944 Michigan Avenue

581-9697

An excellent spot for people with larger appetites, the Beirut Gardens features oversized portions of shish-kabob, baba ghanoush and other Arab specialties. This family-owned diner is open from 11:00 a.m. to 10:00 p.m. \$

Charley's Crab

5498 Crooks Road, Troy, Michigan

879-2060

A short drive will get you to Charley's Crab, one of the area's most unique restaurants. Fresh fish and seafood specialties are served to you in a dining room which was once the living room of Packard Motor Company Executive Alvin Macaulay or in the Farragut Room which is adorned with artifacts from one of America's last square rigged whaling ships. Charley's Crab also offers a raw bar large enough to accommodate 80 people. Lunch is served from 11:30 a.m. until 4:00 p.m. and dinner is from 5:00 p.m. until 11:00 p.m. The raw bar opens at 4:00 p.m. and closes at midnight. \$\$\$

The Grill

300 Town Center Drive

441-2000

Located in the pleasant and plush Ritz-Carlton. Club-like atmosphere featuring grilled steaks, seafood, and a buffet luncheon menu. French and English Continental cuisine. Lunch is served daily from 11:30 a.m. to 2:30 p.m. and the dinner hour is 6:00 p.m. to 11:00 p.m. \$\$\$



Entertainment

Whether you are looking for a leisurely walk through chrysanthemums, a night of laughter, musical dream notes or just a wholesome heart warmer, Detroit has something just for you.

"Mouse Trap"

November 6, 7, 8, & 9
Meadowbrook Theater

An Agatha Christie masterpiece of mystery. A thriller which will keep you on the edge of your seat. It's the longest running play in theatre history! Seats are \$17.00 and \$21.00. For showtimes and reservations contact the box office at 377-3300 (between noon and 5 p.m.).

"Noises Off"

November 8 & 9
WSU Hillberry Theater

Comical look at what goes on back stage before a performance. John Simon calls it, "a side splitting scene," full of laughs! Showtime is 8 p.m. Seats are \$8.00 and \$13.00. Contact the box office for reservations at 577-2972.

"Cotton Patch Gospel"

November 5-10
Detroit Repertory Theatre

The inspiring story of Jesus...retold in a rural Georgia setting. Music and lyrics by Harry Chapin. Dramatic musical to see. All seats are \$10.00. Call for reservations at 868-1347.

"Rigoletto"

November 7 & 9
Fisher Theater

A sixteenth century violent drama in which Rigoletto's daughter is kidnapped and revenge is sought. Showtimes are 1 p.m. and 8 p.m. Contact the box office for reservations and prices at 874-7464.

"Starlite Express"

November 6, 7, 8, & 9
Masonic Temple Theater

Spectacular laser lite musical by Andrew Lloyd Weber. A young boy dreams about a train...all members of the cast perform on roller skates. Exciting and heart warming. Showtime is at 8 p.m. For reservations at Ticket Master call 645-6666.

Detroit Institute of Art

November 5-10

The collection of Alan and Marianne Schwartz: Master Prints of Five Centuries. Admission is free of charge. Hours are 9:30 a.m. until 5:30 p.m.

The Detroit

Symphony Orchestra November 8, 9, & 10

The Detroit Symphony will be presenting "Svedsen, two Swedish folk melodies," "Maritime, Oboe Crescendo," "Hummel Variations in F Major," and "Brahm's Symphony #1 in C Minor" at the Orchestra Hall. Showtime is 8 p.m. For ticket information and reservations call the box office at 833-3700.

Cranbrook Academy of Art Museum

November 1-30

"Cranbrook Design: The New Discourse 1980-1990" Exhibit

Henry Ford Museum

November 1-30

Herman Miller Furniture Collection: A Gift to Henry Ford Museum & Greenfield Village

Detroit Science Center

November 1-30

"To the Limit," Movie at the Omnimax Space Theatre

Belle Isle Conservatory

November 4-25

Chrysanthemum Flower Show

Joe Louis Arena

November 6-11

Walt Disney's World on Ice

Auburn Hills Palace

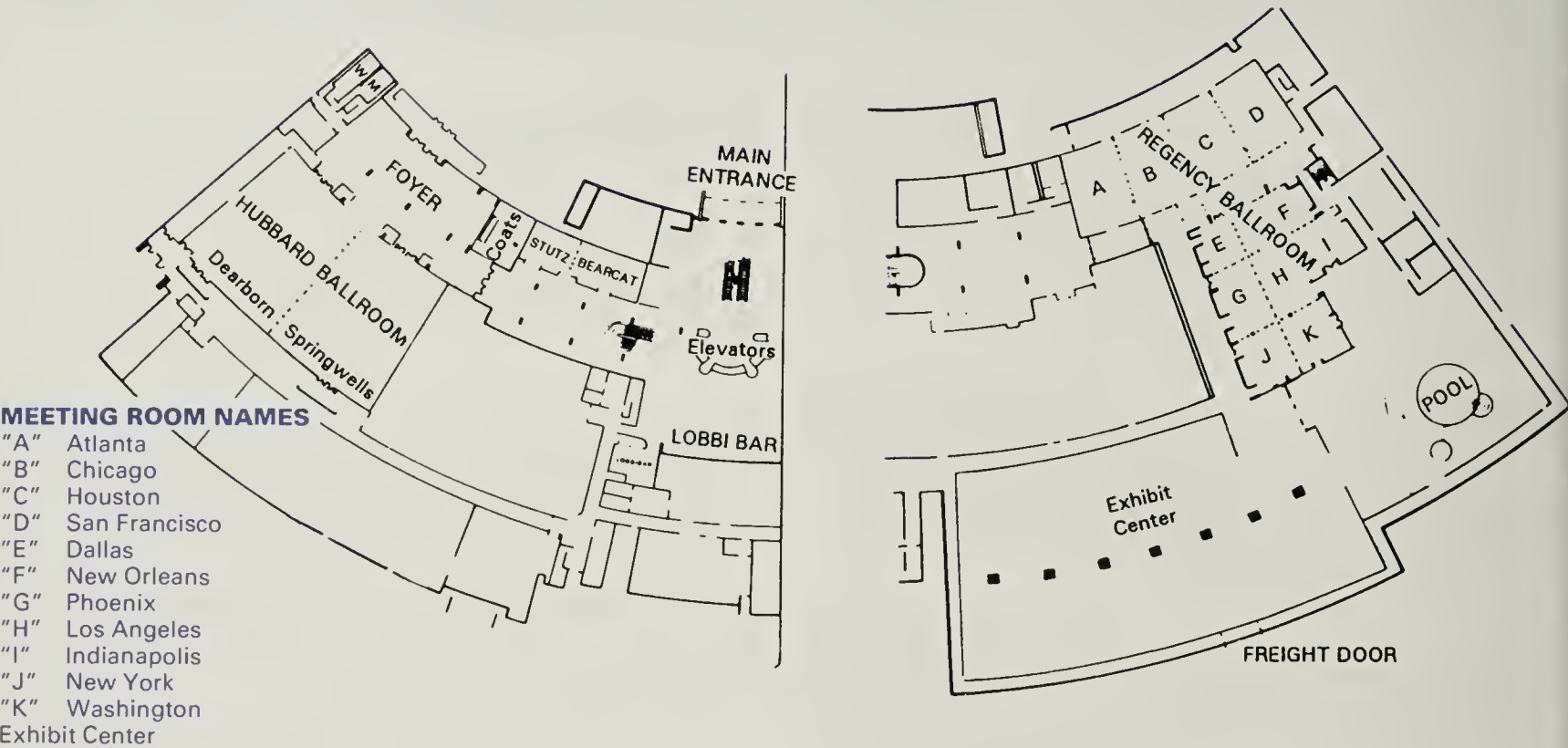
November 7-11

Moscow Circus '90

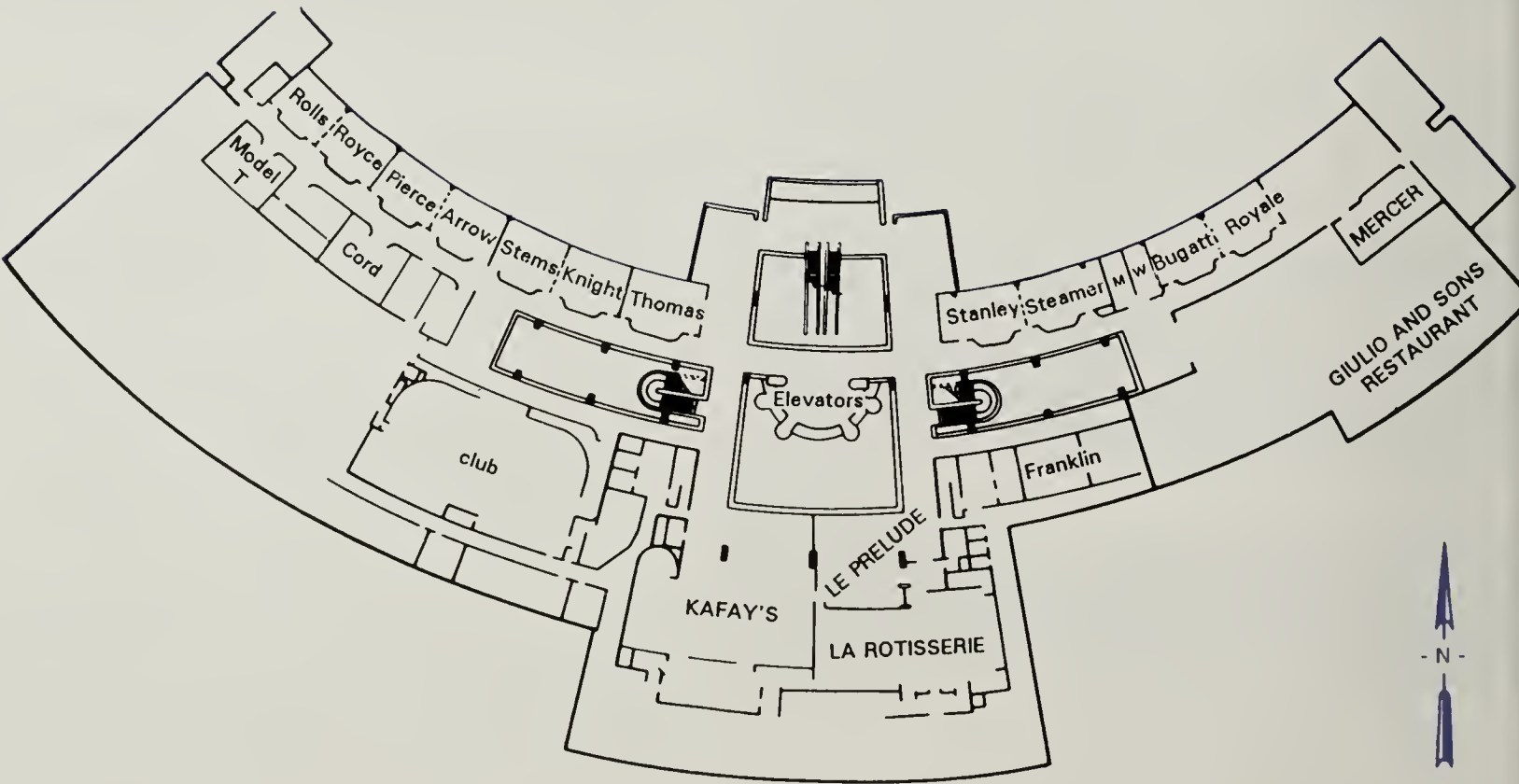


Atrium Concourse Level (First Floor)

1990 MSMS Annual Scientific Meeting November 6, 7, 8 Hyatt Regency Dearborn



Conference Suite Level (Second Floor)



Michigan State Medical Society

in cooperation with its subsidiary

Physician Service Group, Inc.

announces its

1991 Seminar Schedule

Better Billing/Reception Patient Flow

February 5 Detroit
February 6 Lansing
February 7 Grand Rapids

Conomikes Medicare Update

February 12 Detroit
February 13 Bay City
February 14 Kalamazoo

Advanced Coding

February 19 Bay City
February 20 Ann Arbor
February 21 Kalamazoo

ICD-9

March 5 Detroit
March 6 Bay City
March 7 Lansing
October 8 Traverse City
October 9 Grand Rapids
October 10 Detroit

How to Improve Patient Services

March 13 Detroit
March 14 Grand Rapids

IC Collections

March 20 Detroit
March 21 Grand Rapids

MSMS/BCBS Medicare

April 9 Marquette
April 10 Grand Rapids
April 11 Detroit

How to Run a More Profitable Practice

April 16 Kalamazoo
April 17 Bay City
April 18 Detroit

Supervising and Managing Office Staff

April 23 Detroit

Working With People

April 24 Detroit

Estate Planning - 1/2 day

April 24 Detroit

Financial Planning

May 9 Ann Arbor

Health Law Update

May 9 Ann Arbor

Starting Yourself in Medical Practice

June 7-8 Ann Arbor
September 13-14 .. Grand Rapids

MOMI

August 11-15 Traverse City

Improving Productivity

September 11 Detroit
September 12 East Lansing
September 14-15 .. Mackinac

Advanced Coding

September 24 Marquette
September 25 Traverse City
September 26 Grand Rapids

Third Party Reimbursement

October 1 Detroit
October 2 Saginaw
October 3 East Lansing

Retirement Planning

October 16 Lansing

Stress Management

October 17 Grand Rapids

Medicare

October 22 Lansing
October 23 Detroit
October 24 Bay City

Getting the Most Out of Your PC

October 23 Detroit

Health Law Update - 1/2 day

October 23 Detroit

AMA-MSMS Efficiency

November 4-8 To be determined



MICHIGAN STATE MEDICAL SOCIETY

I N S U R A N C E ★ P R O G R A M S

Your personal and professional future depend on your ability to practice medicine.

☐ Loss of that ability means loss of income and security for you, your family and your medical practice.

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Physicians face a variety of year-end tax saving strategies

By Julius Giarmarco, PC



Although tax legislation in recent years was supposed to simplify our tax system, in reality most taxpayers face more complex rules requiring as much planning as before. This article will advise you with respect to some year-end tax saving opportunities. However, before acting on any of these strategies, you should discuss them first with your accountant or tax attorney.

Timing of income and deductions

There are only two marginal tax rates for most individuals – 15 percent and 28 percent. However, a “marginal” rate of 33 percent applies to individuals with larger incomes. In 1990, the 33 percent rate kicks in at a taxable income of \$78,401 for married taxpayers and at \$47,051 for single taxpayers. But once the benefit of the 15 percent tax rate and the personal exemption have been fully phased out, additional income is taxed at 28 percent. Thus, the “effective” tax rate never exceeds 28 percent.

The most popular year-end planning strategy is to time income and deductions. For example, if you expect your marginal rate to increase in 1991, then you should consider deferring deductions and accelerating income. However, most established physicians will find themselves in the 33 percent marginal tax bracket regardless of how they time income and deductions. For these individuals, the only reason to defer deductions and to accelerate income is if they expect, as many people do, that overall tax rates will increase next year.

As this article went to print, Congressional tax writers were proposing an income tax increase for wealthy Americans and a cut in the capital gains tax. If such a change is enacted into law, a strategy of accelerating income into 1990 and of deferring capital gains until 1991 would generally be advantageous.

Certain deductions are only allowed to the extent they exceed certain limits (“floors”). For example, medical expenses are only deductible to the extent they exceed 7.5 percent of adjusted gross income. Un-reimbursed business expenses and certain miscellaneous expenses such as fees for tax advice, are only deductible to the extent they exceed 2 percent of adjusted gross income. Therefore, you should consider a strategy of “bunching” such expenses for two tax years into a single tax year to make certain you exceed the floor.

Interest expenses

Only 10 percent of personal interest paid in 1990 is deductible. The income tax deduction for “personal interest” is eliminated after 1990. Personal interest includes interest on personal debts, credit cards, auto and certain small boat loans, and debts to pay for a college education. Therefore, you should consider paying off personal loans as quickly as possible to avoid further accrual of nondeductible interest. Moreover, consider taking a home equity loan instead of or to replace personal debt. The interest on home equity indebtedness covering the lesser of \$100,000 or the difference between the fair market value of your residence and your acquisition indebtedness related to

the residence, is fully deductible.

Income shifting

The Tax Reform Act of 1986 sharply reduced the opportunity for parents to shift investment income to children. First, given the “compression” of the income tax brackets, many adult children will be in the same tax bracket as their parents. Second, a so-called “kiddie tax” is imposed on the unearned income of children under age 14. Under this tax, the unearned income (e.g. interest, dividends and capital gains) of a child under age 14 in excess of \$1,000 is taxable to the child at the parent’s top income tax rate.

Nevertheless, there are still some strategies available to shift income to children. First, if your children are over age 14, you can shift assets to them without regard to the “kiddie tax.” Second, if your children are under age 14, you can shift enough assets to them to produce up to \$1,000 of total annual unearned income, or you can transfer them assets which generate little or no taxable income (e.g. growth stocks, tax-exempt bonds and life insurance products). Third, by establishing a so-called Section 2503 (c) Trust for children under age 21, any income generated by property held in trust is taxed to the trust at special rates. In 1990, a Section 2503 (c) Trust could have taxable income of up to \$5,450 a year and remain within a 15 percent tax bracket. Finally, if you own your own medical practice, consider hiring your children. Your business can deduct any reasonable pay as a business expense. The “kiddie tax” will not apply because the income is “earned” income.

Continued on page 42

Moreover, if your child is under age 18 and your medical practice is not incorporated, you will not have to pay Social Security taxes on your child's salary.

Planning for gains/losses

Capital gains are currently taxable at the same rates as other income. Capital losses reduce capital gain without limit, but only \$3,000 of net capital losses in excess of gains can be used to offset ordinary income. Therefore, if you have realized a large capital gain in 1990, consider taking a loss on another investment this year to avoid tax on the capital gain. Conversely, if you expect a large capital loss in 1991, you may want to defer selling appreciated property until next year so that more of the loss can be utilized.

If you have already or plan to sell an asset for installment payments extending beyond 1990, consider using the installment method of reporting gain. This method prorates the gain over the tax years in which the payments are received. Moreover, if you sell your principal residence this year at a gain, you can defer the tax on that gain by purchasing a residence of equal or greater value within two years before or after the sale.

Tax-advantaged investments

The Tax Reform Act of 1986 sharply limited the ability to use "passive" losses (e.g. losses from investments in which you do not materially participate) to offset ordinary income (e.g. salaries, interest, dividends and non-business capital gains). Instead, passive losses may only be used to offset income from similar activities. Any disallowed passive losses are carried forward and applied against passive income in future years.

Therefore, if you have non-deductible passive losses, you may want to consider investments that generate passive income against which you can offset those losses. Moreover, if a proposed investment will generate passive losses, generally you should not enter into it unless you have sufficient passive income from other activities to offset the losses. There is an exception to the passive loss rules which permits you to deduct up to \$25,000 of losses from rental real estate activities in which you "actively participate." However, the \$25,000 allowance is phased out ratably as your adjusted gross income increases from \$100,000 to \$150,000.

Retirement planning

Qualified retirement plans still offer the most tax advantaged method of saving for retirement. Therefore, if you own your own medical practice, you should consult with your advisers to make certain that you are taking maximum advantage of a qualified profit sharing or pension plan as a tax shelter. If you work for someone who sponsors a 401 (k) plan, you should attempt to make the maximum salary deferral (\$7,979 in 1990). Moreover, if you work at a hospital that sponsors a 403 (b) plan (tax sheltered annuity), the maximum salary deferral is \$9,500 annually (some exceptions and limits apply). Finally, if your employer does not sponsor any type of qualified retirement plan, you can contribute (and deduct) \$2,000 to an IRA - provided your spouse is not an active participant in his/her employer's qualified plan.

If you received or will be receiving payments from a qualified retirement plan this year, you may have some decisions to make which require careful analysis and planning. Generally, payments from a qualified plan can be taken in the form of an annuity or in a lump sum (although your particular plan may provide for more or fewer options). If you receive a lump sum distribution, you may be eligible to roll over part or all of the distribution into an IRA. If so, you would pay no immediate tax and the rollover proceeds will continue to accumulate tax-free inside the IRA. Alternatively, you can forego rollover treatment and pay immediate tax on the lump sum distribution using five-year or ten-year forward averaging. Generally, forward averaging results in an income tax savings. You should note that not all distributions are eligible for rollover or forward averaging treatment and, therefore, you must consult your accountant and/or tax attorney in this regard.

In any event, the rules governing pension distribution are extremely complex. There are minimum distribution rules beginning at age 70 1/2 and a new 15 percent excise tax on larger distributions (generally those over \$750,000). Therefore, professional advice in this area is essential.

Planning for your practice

If you are a shareholder in a professional corporation, *all* taxable income of your P.C. is taxed at 34 percent. Because of the higher marginal tax rate for professional corporations, most accountants advise their clients to pay out greater salaries to owner-employees so as to eliminate the

corporate tax. While such salaries must be reasonable to be deductible, a professional corporation is less likely to be challenged by the IRS on the reasonableness of the physician's compensation.

If you are contemplating the purchase of medical equipment for your practice in the near future, consider purchasing (and placing in service) such equipment before the end of this year. By doing so, you may secure a half year of depreciation deduction in 1990 even though the asset is placed in service in the last month. However, if you purchase too much equipment in the last quarter of the year, your depreciation deduction could be limited. You should consult your accountant or tax attorney as to the proper timing of such purchases.

Another way to accelerate write-offs for new equipment is the election to deduct as an expense up to \$10,000 of the cost of that equipment. However, the \$10,000 deduction amount is reduced on a dollar-for-dollar basis for purchases in excess of \$200,000. Therefore, if you are approaching the \$200,000 threshold, consider delaying further equipment purchases until next year.

Finally, if you use a cellular phone for business, you must keep the same detailed records that apply to the business use of automobiles in order to be able to deduct such expenses.

Conclusion

This article merely outlines some of the opportunities for tax savings that may be available to you. However, some of the planning opportunities presented may not be appropriate for your situation. Moreover, changes to the tax laws were imminent as this article went to press. Therefore, you should discuss any plans with your accountant and/or tax attorney before you take any action. ■

Julius Giarmarco, PC, is a practicing tax attorney with Giarmarco & Bill, PC, Troy. This article was provided compliments of Physician Service Group, Inc., an MSMS subsidiary.

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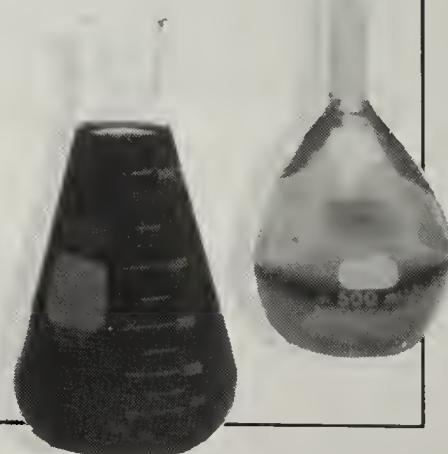
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MSMS issues statement on Physician-Assisted Suicide

The MSMS Board of Directors adopted a statement on physician-assisted suicide at its September 19, 1990 meeting held at MSMS headquarters. Following is the statement in its entirety.

The recent use by a Michigan physician of a "suicide device" to end the life of a patient with Alzheimer's disease attests to concerns deeply felt by many patients — that they will suffer and lose control of their lives as they face chronic and terminal illness. These concerns are reflected in public opinion polls, which consistently show that 50 to 60 percent of Americans favor active euthanasia or mercy killing as an option.

Hypothetically, the decisions that might be made in terminal illness, or severe chronic illness with severely reduced quality of life, are illustrated by the following spectrum:

1. Discontinuing life support measures;
2. Providing patients with sufficient analgesia to control pain, even though this may depress vital functions;

3. Providing patients with enough analgesic or sedative medication to constitute a lethal dose if taken all at once, with the knowledge that the patient may elect to commit suicide by this means;

4. Directly administering a lethal quantity of medication.

Many physicians would allow #1 and #2 while steadfastly opposing #3 and #4, arguing that the physician must be dedicated to healing and never to causing the death of the patient. Others would argue that the complexities of actual clinical cases make it extremely difficult to draw such a sharp dividing line which can be defended with cogent ethical reasoning. For many physicians who accept #1 and #2 while opposing #4, assisted suicide (#3) represents a moral gray zone.

The "suicide device" used in Michigan appears to some in its clinical and ethical implications to be more akin to active euthanasia (#4) than to assisted suicide (#3). While use of the machine may arguably reduce the physician's legal responsibility for the patient's death, the ethical responsibility appears to be as great as if the physician had chosen directly to administer the lethal injection.

It is not enough, however, to righteously condemn the use of this "suicide device", unless we forthrightly address the under-

lying concern of humane and compassionate terminal care for all patients. While these issues are societal, rather than purely medical, physicians nevertheless have a special obligation to make clear our basic professional values.

We encourage all Michigan physicians to enhance the quality of care of these patients in the following ways:

1. Become acquainted with the most modern methods of symptom control and emotional support for palliative terminal care, or learn which local individuals and groups can provide such services for their patients.

2. Assure chronically or terminally ill patients that their consent is required before any medical interventions will be used, and invite them to discuss their wishes and values regarding such care.

3. Become familiar with existing modes of advance directives (durable powers of attorney for health care; "living wills"), ask all patients whether they have executed or wish to execute such documents, and assist them as appropriate in doing so. The MSMS Committee on Bioethics is currently working to compile examples of advance directive documents which appear suitable for use in Michigan. ■

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The MSMS 1990 Public Affairs Leadership Conference, held September 18, in Lansing, offered Michigan physicians a full day of enlightening discussions — all of which were designed to inform physicians about “Innovative Leadership for the 1990s.” Leading the discussion on this topic was Mike Vance, president of Michael F. Vance, Inc., who is considered one of the world’s leading experts on developing and training people. “The key to great leadership today is socialization and fraternization with your staff,” Vance told attendees. “Elitism will go right to your bottom line.” Another popular session was a panel discussion on “Who Will Lead Our Health Care System in the 1990s?” Panelists included MSMS President Susan H. Adelman, MD; Michigan Department of Social Services Medical Services Administration Director Kevin L. Seitz; and Vice President of Planning and Development Services at Blue Cross Blue Shield of Michigan, Marianne Udow. Photo highlights of these and other sessions appear here and on page 48.

Above: More than 70 people attended the 1990 MSMS Public Affairs/Leadership Conference September 18 at the Lansing Radisson Hotel. Topics at this day-long event ranged from a keynote presentation on “Innovative Leadership” to a workshop on “Allocating Health Care Resources in the 1990s.”

Right: Richard A. Stone, MD, chairman of the 1990 Public Affairs Leadership Conference, welcomed attendees to the day-long event, which began with a discussion on leadership by expert Mike Vance, and ended with a tour of the State Capitol Building, a government affairs briefing and a legislative reception.





Left: MSMS President Susan H. Adelman, MD, was one of five speakers who participated in the panel discussion on "Who Will Lead Our Health Care System in the 1990s." In defining her vision for the year 2000, Doctor Adelman said she sees the need for a health care system "financed by patients, paid by employers or by government vouchers paid by taxpayers."

Above: "The 1990s will not be much more than an introductory period to (health care) reform," Kevin L. Seitz, director, Michigan Department of Social Services Medical Services Administration told physicians during the panel discussion on "Who Will Lead Our Health Care System in the 1990s?" With that, he said, will come frustration and alienation, particularly between health care providers and elected officials.



Above: "Health care policy will take a major focus in our public policy debate," Marianne Udow, vice president of planning and development services, Blue Cross Blue Shield of Michigan, told attendees. There will be "no easy answers" to our health care problems, she said, the "issues will only get tougher."

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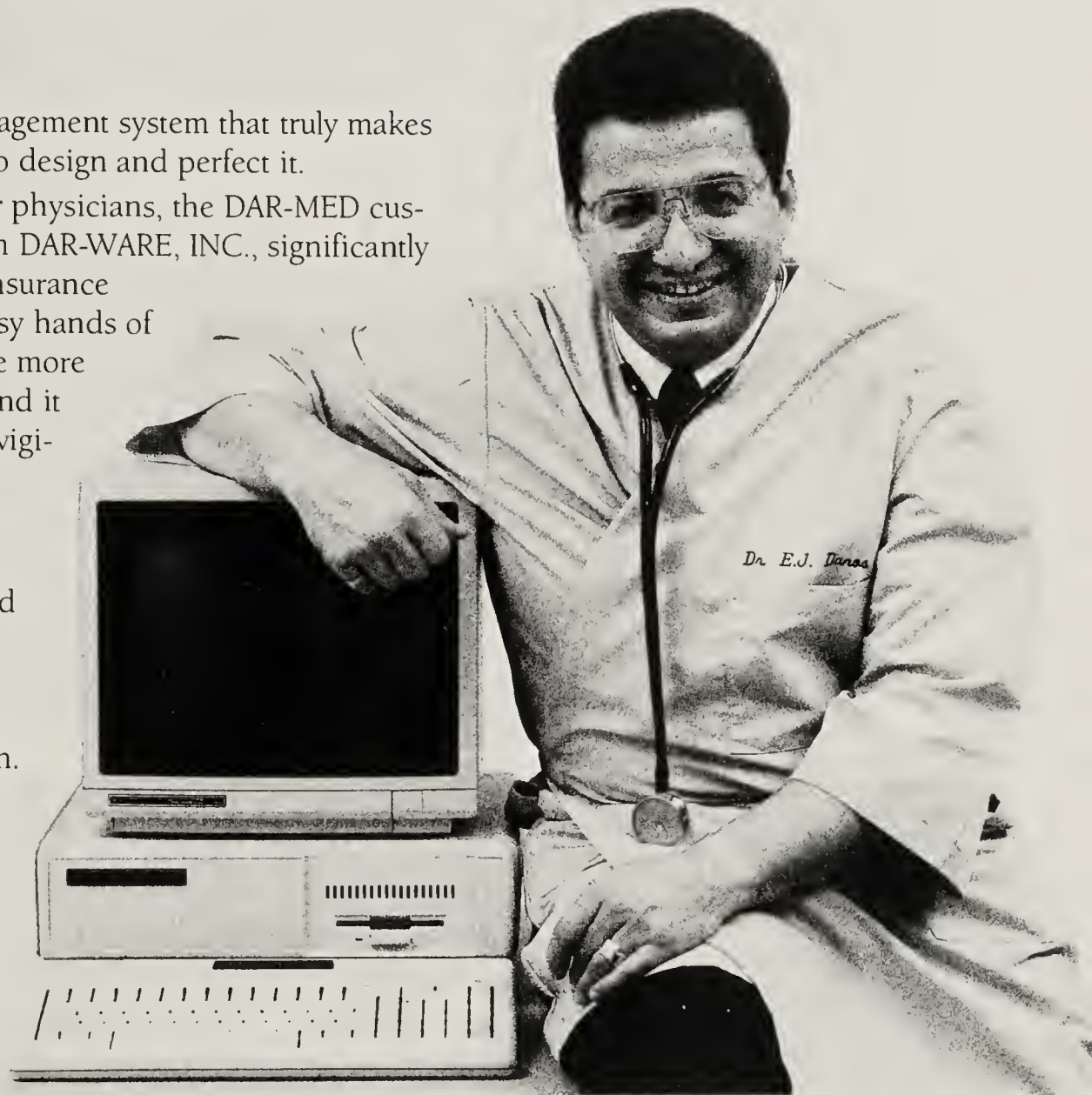
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John Kitzhaber, MD

Discusses Oregon's Basic Health Services Program

John Kitzhaber, MD, president of the Oregon Senate, spoke to Michigan legislators and health care leaders about health care rationing during a breakfast meeting at MSMS headquarters September 19. Later in the day he also addressed the MSMS Board of Directors on the same topic. Doctor Kitzhaber, who is an emergency room physician, developed the Oregon Basic Health Services Program, a plan for rationing health care. "The current system already rations health care to the poor arbitrarily and indiscriminately," Doc-

tor Kitzhaber said. "The Oregon proposal is attempting to focus on those excluded from the system." The plan expands Medicaid coverage to all citizens at or below the poverty level. Previously, only citizens at a certain percentage of the poverty level were covered by Medicaid. Oregon is currently developing a priority list ranking 1,600 health care procedures on effectiveness and cost to determine what health care its citizens will be entitled to. ■



The Oregon plan calls for a basic level of health care coverage for every Oregonian, Doctor Kitzhaber told MSMS Board members and special guests at MSMS headquarters September 19. Those on Medicaid, the unemployed, and the working poor will be covered by a basic plan of benefits developed through a public process. All employers will be required to offer their employees this basic coverage, either as a benefit or through a cost sharing plan.



Vernon K. Smith, deputy director, Medical Services Administration, Michigan Department of Social Services (right) took the opportunity to question Doctor Kitzhaber about the Oregon plan. Smith was one of several special guests invited to attend the meeting.



Rationing of health care will occur under the Oregon plan, Doctor Kitzhaber said, because the basic plan will prioritize 1,600 procedures on efficacy of outcome and cost effectiveness and then limit the number of procedures available based on the funding level established by the legislature. He pointed out, however, that rationing already exists for patients with little or no insurance and those on Medicaid who can't find a physician willing to accept them.

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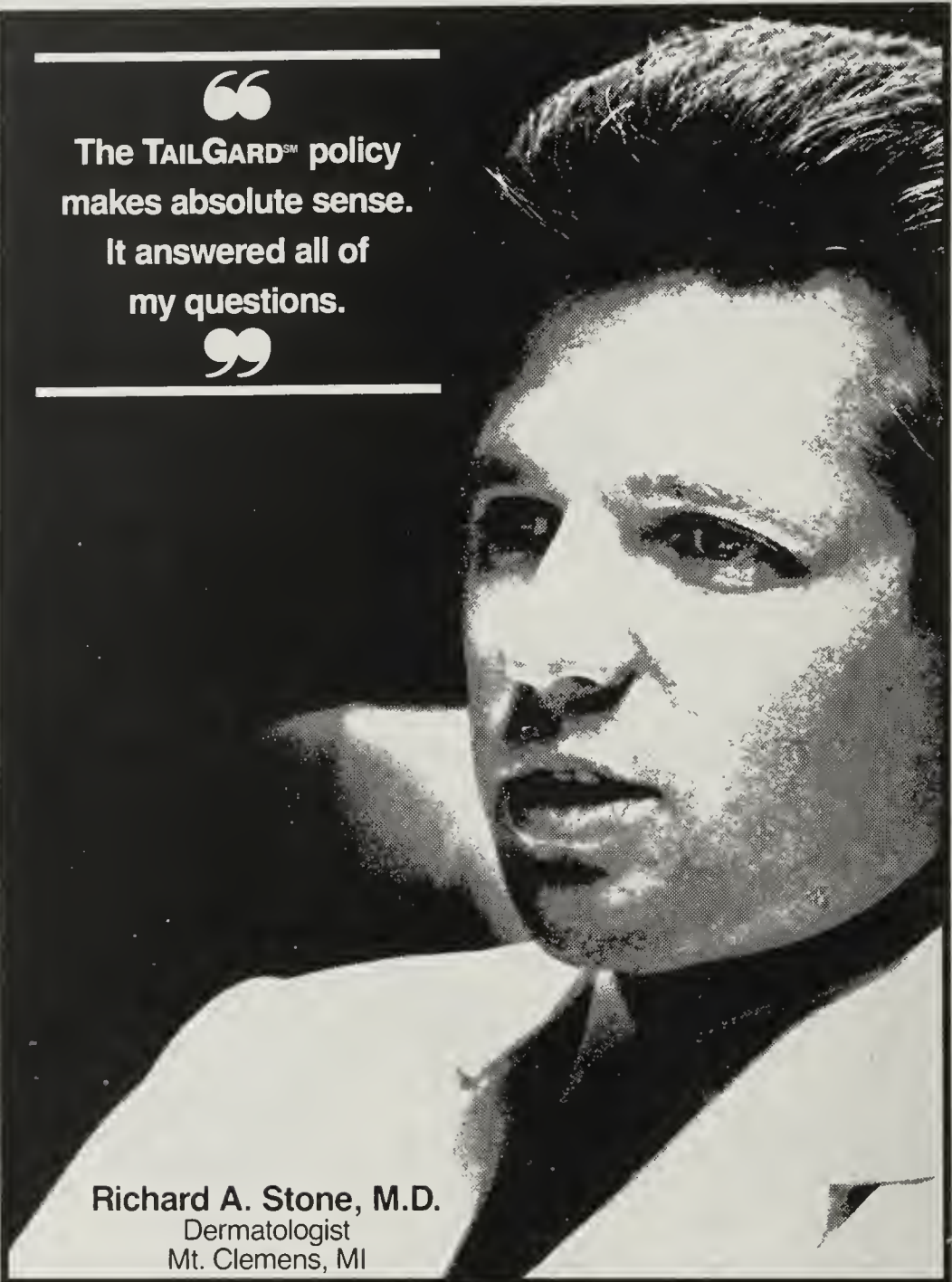
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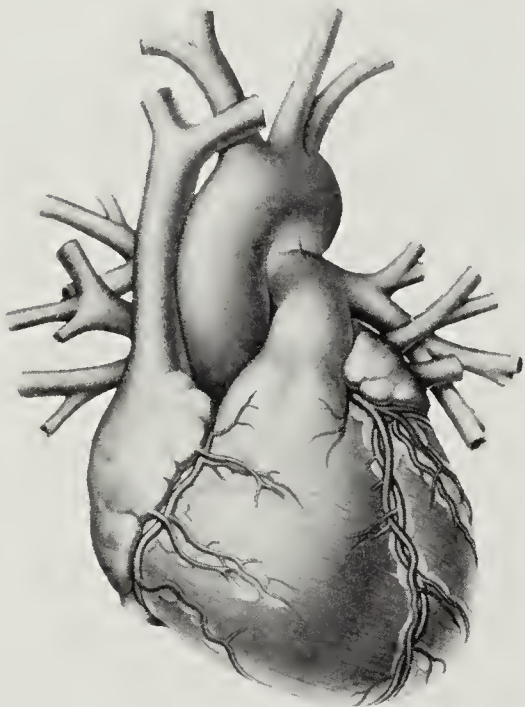
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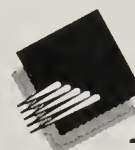
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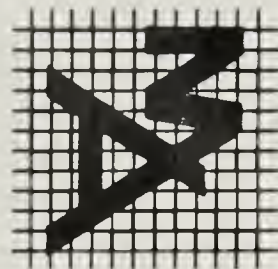
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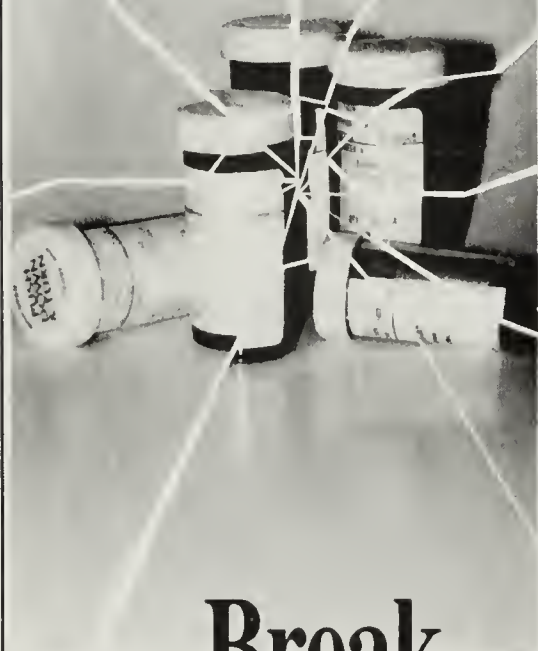
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DEATHS

Alfredo B. Arriola, MD *Grosse Pointe Woods*

Alfredo B. Arriola, MD, a general surgeon, died August 23. He was 56. Doctor Arriola was a 1961 graduate of the University of Santo Tomas, Manila, and was a former president of the Philippine Medical Association of Michigan. He was chief of staff and chairman of the Department of Surgery at Riverview Hospital, Detroit. He was formerly chief of staff and chairman of the surgery department at Samaritan Health Center. Doctor Arriola was a member of MSMS.

Gerald M. Breneman, MD *Farmington Hills*

Gerald M. Breneman, MD, a cardiologist, died August 21 at the age of 66. Doctor Breneman received a bachelor of science degree in 1944 from Franklin and Marshall College, then earned his medical degree from Jefferson Medical College. He interned at Henry Ford Hospital in 1949-50, and completed his residency there in 1955. He became the senior associate physician at Henry Ford Hospital, Division of Cardiovascular Medicine, in 1955. He held that position for the past 35 years. In addition, Doctor Breneman was a clinical assistant professor of internal medicine at the University of Michigan Medical School for 18 years. He was awarded the Inter-Society Commission for Heart Disease Resources in 1971 and MSMS Flag Award in 1972. Doctor Breneman was president and secretary-treasurer of the Detroit Heart Club, a member of the MSMS and numerous other professional organizations.

James R. Cripps, MD *Marlette*

James R. Cripps, MD, a general practitioner, died August 21. He was 73. Doctor Cripps earned a degree in education from Eastern Michigan College, and a medical degree from the University of Michigan Medical School in 1944. In 1950 he established his practice in Marlette and served as chief of staff at the Marlette Hospital as well as president of the Sanilac County Medical Society. He was a member of MSMS.

Russell N. DeJong, MD *Mt. Pleasant*

Russell N. DeJong, MD, a neurologist, died August 20 at the age of 83. Doctor DeJong earned his bachelor's degree in 1929 and his medical degree in 1932 from the University of Michigan. He served an internship and resi-

dency in neurology there, and received a master's degree in neurology in 1936. He became certified by the American Board of Psychiatry and Neurology three years later. He also became an instructor in neurology at the University in 1936, and was promoted to associate professor in 1941. Nine years later he became professor and chairman of the U-M Department of Neurology, a position he held from 1950 to 1976. After retiring, he was named professor emeritus of neurology, a title he held until his death. He authored a textbook, *The Neurologic Examination*, in 1950 and it subsequently was published in four editions. Doctor DeJong was the founding editor of *Neurology*, the official journal of the American Academy of Neurology and held that post from 1950 to 1976. He was one of the organization's founders and a former vice-president. His last book, *A History of American Neurology*, was published in 1982. He served as president and was a member of the American Neurological Association, the American Epilepsy Society and the Michigan Neurological Association. He helped start the Pan American Congress of Neurology and was a consultant to the surgeon general of the Army Far East Command. He was awarded the Fulbright Research Fellowship to the National Hospital, Queen Square, London, England. He was affiliated with the World Federation of Neurology and was a member of MSMS.

Irving I. Edgar, MD *Southfield*

Irving I. Edgar, MD, a psychiatrist, died August 17. He was 88. Doctor Edgar earned his bachelor of science and master degrees from Wayne State University and attended the Wayne State School of Medicine, and the University of Michigan Neuropsychiatric Institute. He began his private practice in 1943. He was assistant medical director at St. Clair Hospital from 1958 to 1970. He was director of clinical service at the Island View Adolescent Center in Detroit from 1972 to 1974. Doctor Edgar served on the psychiatric staffs of Sinai, Crittendon, Grace, Jennings, Detroit Memorial and South Macomb hospitals. He had a longtime private practice in the David Whitney Building in Detroit. He was the author of five books and numerous articles. Doctor Edgar was a member of the MSMS.

Bernard P. Kool, MD *Cascade*

Bernard P. Kool, MD, a family practitioner, died September 8. He was 65. Doctor Kool

received his medical degree from the University of Michigan in 1950. He had a family practice in Grand Rapids from 1954 to 1973. Doctor Kool was the former Kent County medical examiner, a position he held for 25 years, and medical director of the Michigan Veterans Facility from 1973 to 1990. He had just retired from practice in April. He was also a past president and member of the Kent County Medical Society, past president of the Kent Medical Foundation, and a member of MSMS.

John K. McCormick, MD *Grand Rapids*

John K. McCormick, MD, a general practitioner, died August 14. He was 75. Doctor McCormick earned his medical degree from Marquette University, Milwaukee, Wisconsin in 1943. He practiced as a general practitioner on the north side of Grand Rapids and at St. Mary's Hospital for 35 years until his retirement in 1979. Doctor McCormick also served as emergency room physician for the State of Michigan at Hackley and Mercy hospitals in Muskegon. He was a member of the Kent County Medical Society and MSMS.

Robert D. Risk, MD *Muskegon*

Robert D. Risk, MD, a general practitioner, died June 25. He was 82. He was a 1933 graduate of the University of Michigan Medical School and did his postgraduate work at W.A. Foote Memorial Hospital, Jackson. He then moved to Muskegon where he became affiliated with Hurley and Mercy hospitals. Doctor Risk had practiced medicine for 53 years. He retired in 1987. He was a member and past president of the Muskegon County Medical Society. He also was a member of the American Academy of Family Practice, the American Medical Association, and MSMS.

Harold M. Rosen, MD *Rochester*

Harold M. Rosen, MD, an obstetrician/gynecologist, died July 31. He was 75. Doctor Rosen was a 1938 graduate of Wayne State University School of Medicine. He served as a former staff member at Sinai and Hutzel hospitals. Doctor Rosen was a member of the American Medical Association, the American College of Obstetrics and Gynecology and MSMS.



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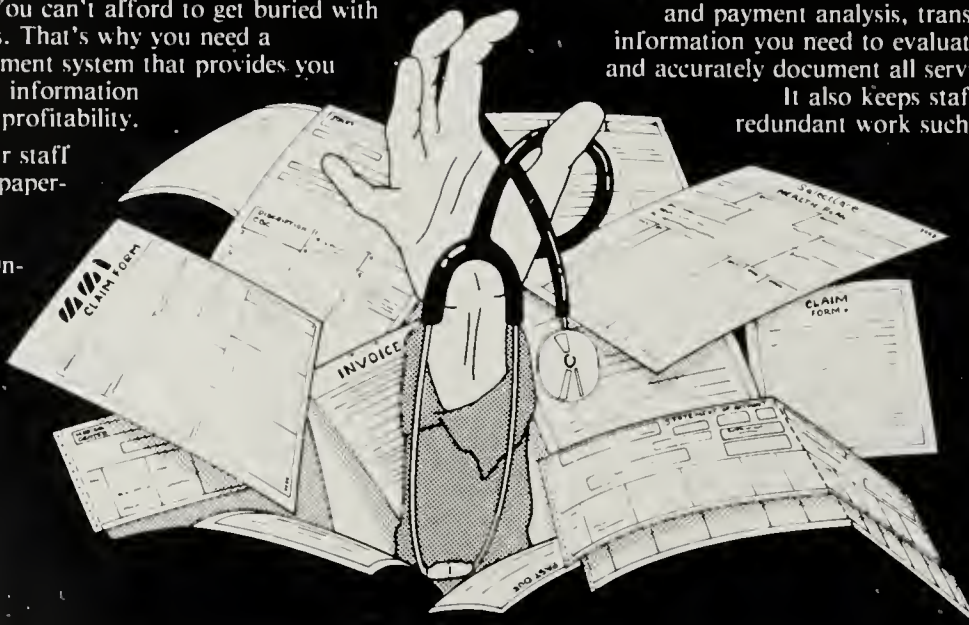
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MEETINGS

MSMS Meetings

November

6,7,8, MSMS Annual Scientific Meeting. Hyatt Regency, Dearborn, MI. Contact: Sherry L. Fent, Chief, Physician Education (517) 337-1351.

13-16, MSMS/PSG/AMA, Office Staff Training, Hyatt Regency, Dearborn, MI. Contact: Amy Fistler, PSG, Assistant to General Manager (517) 336-7570.

AMA Meetings

December

2-5, Interim Meeting of the House of Delegates, Marriott's Orlando World Center, Orlando, FL. Contact: Stephanie Jaworskyj (312) 464-5341.

February

15-17, National Leadership Conference,

Fontainebleau Hilton, Phoenix, AZ. Contact: Stephanie Jaworskyj (312) 464-5341.

Michigan Specialty Society Meetings

November

8,15,29, Michigan Psychoanalytic Institute Discussion Series for Parents; Adolescence. Contact: Michigan Psychoanalytic Institute, Extension Division (313) 559-5855.

10, Inflammatory Bowel Disease: Update for the 90's. Contact: N.F.I.C. - Michigan Chapter (313) 354-6080.

16, 1990 Fall Residents Conference. Contact: Julie Nelson, Administrative Assistant (517) 482-7410.

17, Michigan Psychoanalytic Society: 16th Annual Symposium; Perversion and Object Relations; Sexual Misuse of Persons. Contact: John J. Hartman, Chairman (313) 559-5855 or (313) 557-8633.

National Specialty Society Meetings

November

5-9, Diagnostic Radiology Seminars. Maui, HI. Contact: Renee Sauers (415) 476-5731.

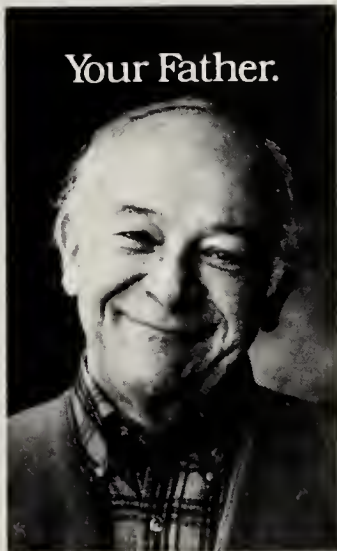
15-17, American Society of Abdominal Surgeons; Interim Meeting. Tampa, FL. Contact: Pauletta Reid, Administrative Secretary (312) 645-4412.

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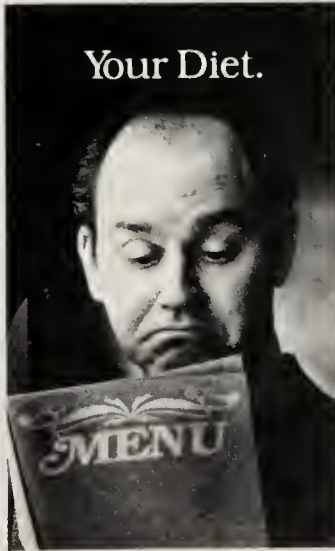
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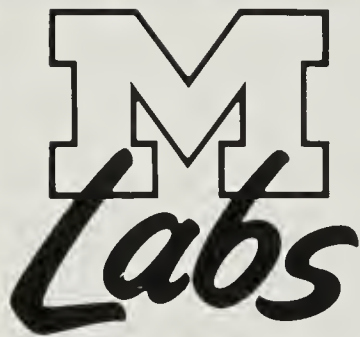
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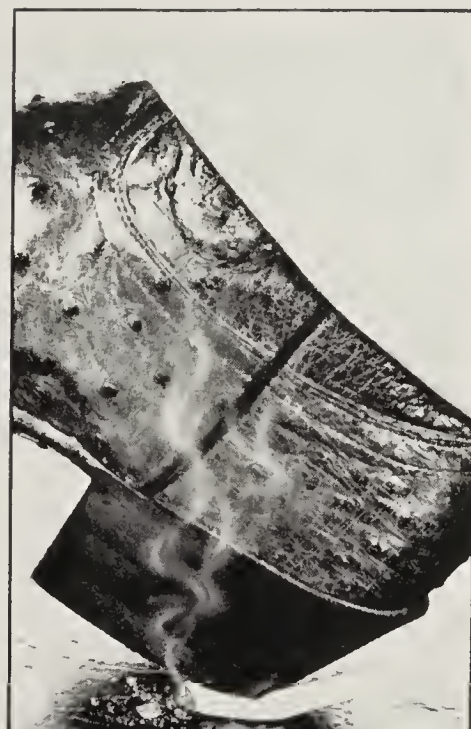
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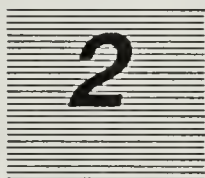
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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

November

5-6, Endothelial Cell Injury. Location: Eleanor N. Dana Center, Toledo, Ohio. **Sponsor:** Medical College of Ohio. **Contact:** Susan Hahn, Office of Continuing Medical Education, Medical College of Ohio, P. O. Box 10008, Toledo, OH 43699-0008. (419) 381-4237. **Approved for:** 12 hours Category I Credit.

8-9, Congenital Anomalies. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pediatrics and Communicable Diseases. **Contact:** Julie Jacobs, Registrar, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 15 hours Category I Credit.

8-9, Advanced Pediatric Life Support. Location: Children's Hospital, Detroit, Michigan. **Sponsor:** Michigan Chapter, American College of Emergency Physicians. **Contact:** Kathryn M. Hopkins, Director, Michigan Chapter, American College of Emergency Physicians, 500 Lansing Road, Charlotte, MI 48813. (517) 645-8050. **Approved for:** 14 hours Category I Credit.

9-10, 38th Annual Detroit Trauma Symposium. Location: Harper Hospital, Detroit, Michigan. **Sponsor:** Harper Hospital. **Contact:** Marjorie Norum, Department of Surgery, Harper Hospital, Detroit, MI 48201. (313) 745-2345. **Approved for:** 8.5 hours Category I Credit.

13-14, Child Abuse and Neglect. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313)

763-1400. **Approved for:** 12 hours Category I Credit.

17, 16th Annual Symposium. Perversion & Perverse Phenomena in Clinical Practice: Current Psychoanalytic Views. Location: The Fairlane Club and Manor, Dearborn, Michigan. **Sponsor:** Michigan Psychoanalytic Society. **Contact:** The Michigan Psychoanalytic Society, 16310 West Twelve Mile Road, Suite 204, Southfield, MI 48076. (313) 557-8633. **Approved for:** 6 hours Category I Credit.

28, Medicine Potpourri. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo, Michigan. **Sponsors:** Michigan State University, Kalamazoo Center for Medical Studies. **Contact:** Charles L. Zeller, Jr., MD, 1535 Gull Road, Suite 230, Kalamazoo, MI 49001. (616) 383-7363. **Approved for:** 4 hours Category I Credit.

29, Second Annual Modern Perinatal Problems. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 16 hours Category I Credit.

30, Psychiatry Update 1990. Location: Ritz-Carlton, Dearborn, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 11 hours Category I Credit.

December

1, Nutrition and Gastrointestinal Diseases. Location: Eleanor N. Dana Center, Toledo, Ohio. **Sponsor:** Medical College of Ohio. **Contact:** Susan Hahn, Office of Continuing Medical Education, Medical College of Ohio, P. O. Box 10008, Toledo, OH 43699-0008. (419) 381-4237. **Approved for:** 6 hours Category I Credit.

1, Psychiatry Update 1990. Location: Ritz-Carlton, Dearborn, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 11 hours Category I Credit.

1, Second Annual Modern Perinatal Problems. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 16 hours Category I Credit.

6, Update in Cardiovascular Disease 1990. Location: Eleanor N. Dana Center, Toledo, Ohio. **Sponsor:** Medical College of Ohio. **Contact:** Susan Hahn, Office of Continuing Medical Education, Medical College of Ohio, P. O. Box 10008, Toledo, OH 43699-0008. (419) 381-4237. **Approved for:** 6 hours Category I Credit.

6, Recent Advances in the Surgical and Non-Surgical Management of Complex Hepatobiliary and Pancreatic Disorders. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Surgery. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 7 hours Category I Credit.

7, Basic Life Support for Health Professionals. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gwen Goldfarb, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 5 hours Category I Credit.

8, Advanced Cardiac Life Support Instructor Course. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gwen Goldfarb, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 7 hours Category I Credit.

14-15, Advanced Trauma Life Support. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, The Michigan Committee on Trauma, and The American College of Surgeons. **Contact:** Teresa Mitchell, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201. (313) 763-1400. **Approved for:** 18 hours Category I Credit.

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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

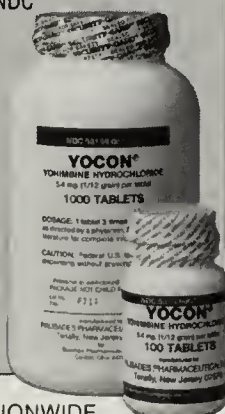
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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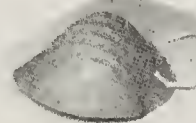
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To help you refine your personal style of leadership, develop your professional decision-making and problem-solving abilities, and enhance your repertoire of management skills, the AMA is pleased to offer Interactions, the 1990 Medical Staff Leadership Program. It offers ample opportunity for leadership skill-building, self-assessment, frank conversation and feedback.

Program Participants

If you are a new chief-of-staff, department director, committee chairman or you serve in any other leadership capacity, the AMA's new Interactions can provide you with the self-assurance and skills you need to be successful in this challenging new role.

Leadership Objectives

- Improve emerging medical staff leaders' understanding of skills needed to perform formal duties.
- Enhance the understanding of medical staff leadership conflicts inherent in today's healthcare scene.
- Increase ability to interact effectively with medical staff peers and hospital/governing body leadership.

Location and Date

The AMA Medical Staff Leadership Program will be conducted on Thursday, November 29, 1990, at the Peabody Orlando Hotel, in Orlando, Florida. For ease of accommodations and travel, the AMA offers the program one day prior to the 1990 Hospital Medical Staff Section Interim Meeting, and three days prior to the 1990 AMA Interim Meeting.

Registration

For immediate registration or information, call toll-free 1-800-621-8335. Please have your MasterCard or Visa ready.

Registration fee

AMA Member - \$275
Non-member - \$375



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POSITIONS OPEN

CHIEF, BUREAU OF LABORATORY & EPIDEMIOLOGICAL SERVICES: The position reports directly to the State Health Director. Duties are to manage Bureau operations, including the diagnostic and biologic products production laboratory and epidemiology functions; to serve as consultant to the State Health Director on establishing the policies of the Department and accomplishing its missions in the field of public health services for citizens of Michigan, particularly as they relate to the medical, scientific and epidemiological aspects of communicable and other diseases; to interface with other Department bureaus/centers/offices as well as state, federal or international agencies to develop new or improved approaches to communicable diseases; and to assist in the legislative process. A degree in medicine, osteopathic medicine, or veterinary medicine,

in addition to extensive administrative/managerial experience is highly desirable. This position is located in Lansing, Michigan. If you are interested in applying for this position, please submit a curriculum vita by November 30, 1990, to: **Janet Washington, Michigan Department of Public Health, PO Box 30195, Lansing, MI 48909.** An Equal Opportunity Affirmative Action Employer.

COMMUNITY OF BEAVERTON, MICHIGAN, is recruiting for a full-time **Family Practitioner** to provide physician services to the residents of their area. Beaverton, located in Gladwin County, is in one of the fastest growing areas of the state and is known for its fishing, hunting, and other popular outdoor activities. The area is served by Mid-Michigan Regional Health System with affiliate hospitals in Gladwin, Clare and Midland. Offering a broad range of comprehensive medical services. For complete information regarding our competitive financial package, and the Beaverton area, please write to: Mike Mikolaizyk, president, Beaverton Business Association, 352 N. Ross, Beaverton, MI 48612.

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ALLERGIST, INTERNAL MEDICINE, FAMILY PRACTICE: A progressive, 126-bed, two-hospital system is seeking the above specialties to establish practices in the Iron Mountain area of Michigan's Upper Peninsula. Must have BE/BC. Located 100 miles north of Green Bay, Wisconsin. Dickinson County Hospital has a medical staff of 45 full-time physicians and a total service area population of over 45,000. Diagnostic capabilities include a CT scanner, CO2 laser, and a fully-staffed special diagnostic department. **CONTACT:** John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, MI 49801, (906) 779-4500.

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FAMILY PRACTICE – HOSPITAL-SPONSORED clinic opportunity. Dynamic, growth-oriented hospital in beautiful North Central Wisconsin is seeking two family physicians for a new clinic facility currently being constructed. The administrative burdens of medical practice will be minimized in this hospital-managed clinic. The hospital has committed to an income and benefit package which is significantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus, and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact Dan McCormick, President, Allen McCormick, France Place, Suite 920, 3601 Minnesota Drive, Bloomington, MN 55435, (612) 835-5123.

FAMILY PRACTICE MINNESOTA – Physician needed for **employment** or **ownership** of broad based practice in rural community 45 minutes south of metro area. Existing shared call, tremendous earning history of retired physician, fully equipped and staffed office. Near outstanding hospital with all specialties represented. Guaranteed compensation, full benefits, bonus. For this and other opportunities in the Upper Midwest, send CV to: Mary Jo Cordes, MDsearch, P. O. Box 21507, Saint Paul, MN 55121. Call Collect (612) 454-7291.

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Thanks to Our Advertisers

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Advance Medical & Metpath	58
Allied Office Interiors	60
American Doctors Association	64
Bennethum Computers	64
Beyond Business Technologies	53
Blue Cross Blue Shield of Michigan ..	6
CBC Labs	46
Cellular One	43
Colonial Valley Software	69
CRT Management	60
Dar-Ware	49
Davis Smith	63
Eli Lilly	38
The Equitable	4
G.D. Searle	21-22
KAB Gloves	67
Kidder Peabody	61
Lab of Clinical Medicine	8
M-Labs	62
M-Line	BC
McDonald & Co	50
Medical Automation	57
Medical Billing Service	2
Medical Computer Consultants	62
Medical Search Group	73
Medical Systems Development Corp ..	52
Metric Medical	44
Michigan Bell	12
MPMLC	IFC,54
Ortho. Physical Therapy	73
Palisades Pharmaceutical	66
PC Medical Management	64
Physician Service Group	1
PICOM	13
Polci	56
Prescott, Ball & Turben	73
Randolph Medical	67
Rollins Healthcare Data Systems	44
St. Luke's	72
Target Equipment	31
Troy Software	56
US Air Force	37

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PRESIDENT'S PAGE

The word for the future is data

By Susan H. Adelman, MD



Data — it's the word for the future. Conference speakers tell us this, and so do the media. The October issue of *Michigan Medicine* described the Michigan Health Data Corporation, a voluntary corporation set up because third party payers demand data about hospitals and physicians. The same issue contained the first installment of a new health care system data presentation, the *Medical Inquirer*.

Still we need far more data. In our own offices, HMOs, PPOs, and hospitals hound us for more data about our practice patterns and their costs. Most of us need far more data in order to intelligently evaluate whether a fee schedule, a capitation, or a risk-sharing program is feasible for us. Very few of us can accurately identify our costs of doing business per medical service or procedure, or per insurer, in order to judge the acceptability of payments we are offered.

Hospitals are little better. The new BCBSM contract obligates hospitals to identify utilization data, and soon it will require quality assurance data. Most hospital management information systems are incapable of coming up with the information the insurer wants. Most hospitals cannot even sort out their total volume of business, costs of doing business, profits and losses per insurer. How are they to decide whether an HMO or PPO contract is worthwhile to them?

Perhaps it does not matter anyhow. Most HMOs and PPOs cannot tell their

volume of business, profits or losses per hospital, per physician, per diagnosis, or per service. Almost without exception, they cannot correlate paid claims data with utilization data or with outcomes data, nor can most of them even identify their hospital admissions on a concurrent basis in order to do concurrent review. Anyhow, they do not even have the data to tell whether concurrent or retrospective utilization review is even worthwhile, since they do not have data to compare the cost of utilization review with actual cost savings.

BCBSM has initiated a Physician Retrospective Profiling project without having the capacity to know which doctors are specialists or sub-specialists, or whether a doctor does an unusual number of certain procedures because he or she is a well-known expert. Nevertheless, they send out letters casting aspersions on doctors with data variations from their peers.

Reliable data needed

For years, physicians have argued with BCBSM, unions and payers about co-pays and deductibles. We argue that they are essential in order to curb patient over-utilization. Payers and unions disagree. We still do not have reliable data which answers this question once and for all. We have another long-standing argument in which we say that lowering payments leads to higher frequencies of service, and payers say that lowering payment for a high frequency service will lower its frequency. It is unbelievable, but nobody seems to have the data to settle this one either.

In the area of professional liability, we are still arguing about whether the insurance commission's estimates of the number of doctors practicing in Michigan contradicts our data about the number of doctors leaving the state after residency. Nobody seems to have reliable data about the number of Michigan physicians in active practice, per specialty, or per region, and whether these numbers are either declining or increasing at a rate less than the national average. Certainly there does not seem to be data to confirm or contradict

the widely held assumption that Medicaid patients sue more. We do not even know which tort reforms or alternate forms of dispute resolution we should pursue most vigorously, because we have no idea how much each separate reform would be expected to lower our premiums. The data is just not there.

Health planners, in Michigan and across the country, contemplate restructuring the entire health care system with no data at all about the potential impact of their proposals on taxes, on governmental budgets, on the viability of hospitals, or on access to physicians. Many ideas are under discussion, but in all this mish-mash, the essential questions are still: Who is helped? Who is hurt? The data is not available.

Lack of data ironical

The irony is that this is the age of information. All of us are bombarded with voluminous amounts of information on a daily basis. How could anyone ask for more? The answer is that much of the information that now overloads us is useless, and that much of the information that we really need is not available. In most cases, we have not even thought about the questions we want to ask. We are so busy wading through all the other glop that we hardly have time to consider what we really want to know or how to find it out.

At any rate, the above list is a start. If some of you have systems that will answer some of the important questions, you may have a bright entrepreneurial future. If others of you have found the perfect software package to run your offices, and you are interested in sharing, perhaps you would be willing to tell MSMS the name of the program, so we can tell other MSMS members. If the demand is out there, MSMS can start evaluating available systems on behalf of our members. All we need, in short, is the right information about your needs. ■

Doctor Adelman is MSMS president.

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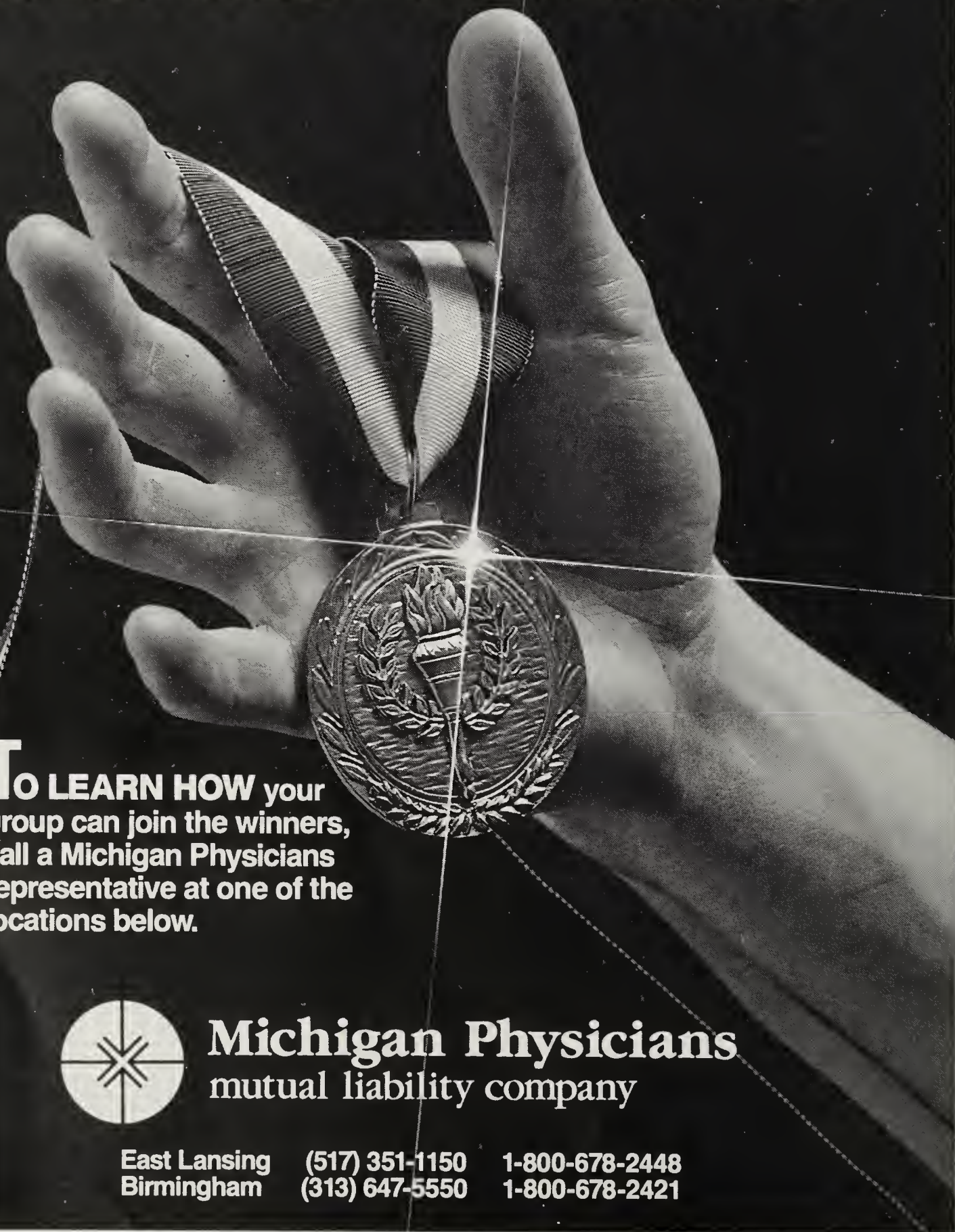
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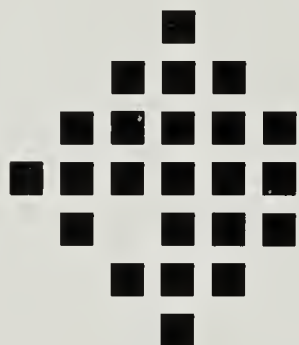
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14 COVER STORY

At least 40 states have enacted laws legalizing living wills. Unfortunately, Michigan is not among them. For many years, MSMS has discussed the need for living wills and has supported legislation, more or less behind the scenes. MSMS is now involved in a more proactive stance, trying to encourage more discussion and wider use of living wills, whether or not legislation is enacted. In this month's cover story, Howard Brody, MD, chairman of the MSMS Committee on Bioethics, reviews some basic terms and ethical principles surrounding living wills, recounts the deliberations of the MSMS Committee on Bioethics on this topic, and indicates why the time is now ripe for more action by Michigan physicians. Also included in this cover story is an article by Richard D. Weber, MSMS legal counsel, which examines the legal considerations of living wills; an article by John V. Hartline, MD, on the capability of patients to participate in health care decisions; and finally, a copy of a living will document prepared by legal counsel for the Genesee County Medical Society.



Page 14

FEATURES

27 MEDICAL INQUIRER FACTSHEET

This is the second in a series of factsheets prepared by the MSMS Department of Economics and Health Care Delivery featuring data and trends affecting Michigan physicians. Readers are encouraged to tear it out and save it for handy reference.

30 PHYSICIANS RECOVERY NETWORK

An indepth profile. — BY CLAUDIA SKUTAR

35 LOW-INCOME AIDS PATIENTS RECEIVE ASSISTANCE

— BY SCOTT D. MERWIN

38 ADEQUATE DOCUMENTATION VITAL TO PEER REVIEW PROCESS

— BY DONALD H. KUIPER, MD

41 PRACTICE MANAGEMENT

A leading expert on practice management discusses how your back office can cost you precious time and money. — BY GEORGE S. CONOMIKES

43 IN MEMORIAM: ROBERT M. LEITCH, MD

— BY THOMAS R. BERGLUND, MD



Page 41

DEPARTMENTS

5 In My Opinion
*"Physicians must be wary
of information glut"*
BY JOHN W. HALL, MD

7 Letters

9 Newsfronts

10 Physicians in the News

45 New Members

48 Category I Courses

51 Meetings

52 Classifieds

57 Advertising Index

58 President's Page

*"We need to do more things
that benefit MSMS members only"*
BY SUSAN H. ADELMAN, MD



Page 43

In next month's issue of *Michigan Medicine*:
Access to Obstetric Care, plus the program for the 30th
Annual Michigan Conference on Maternal & Perinatal Health.
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IN MY OPINION

Physicians must be wary of information glut

By John W. Hall, MD



For thousands of years, physicians have struggled from a lack of knowledge and technology. They have been plagued by patients with ill-defined symptoms such as fever or pain. But without the understanding of germ theory or the availability of antimicrobials, without the ability to image diseased organs or the surgical skills to remove them and without a system to catalogue and retrieve medical advances, little progress was made until the 20th century.

If our recent past serves as a window to the future, technological advances will continue on a logarithmic curve. Already, many physicians are overwhelmed by the requirements of continuing medical education. If we are not already there, we will soon be at the point where medicine will suffer from an information glut.

More not necessarily better

Can there be such a thing as too much information? The answer is yes, especially if we are inundated with irrelevant facts. More information or technology is not better if it doesn't apply to the problem at hand. Our present challenge is to filter and condense the available knowledge base. We need to become more sophisticated by requesting only the information we need to solve our present problem. There will always be uncertainty in the

clinical setting; and when faced with this uncertainty, we have to know when to stop ordering tests, to defer the use of additional technology and to proceed with care based on our clinical skills.

If we can find a solution to the medical liability problem and the subsequent need for defensive medicine, we can then concentrate on honing our information gathering skills.

We must also be knowledgeable in how information is being compiled and used. As the volume of information increases, so does the possibility of cataloguing error. Computer programmers have the saying, "Garbage in = garbage out." Incorrect information can be more dangerous than no information at all. The computerized files being compiled by the HHS Databank must be accurate, or harm will be the by-product. We must be prepared to challenge not only the facts, but also the information storage and retrieval system itself.

Finally, although we are faced with an information glut, we must never quench our thirst for new knowledge and technology.

The use of practice parameters will help us define the limits of our expected clinical inquiry. Yet, with appropriate justification or under the controls of a research protocol, we must not deter from obtaining additional information about our patients and their disease processes. Society will continue to support the efforts of its medical care system as long as physicians remain fiscally judicious in their requests and focused in their use of information systems and technology. ■

Doctor Hall is a member of the MSMS Board of Directors and the MSMS Committee on Publications.

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Letters from Our Readers

Safe disposal of radioactive wastes needs physician support, direction

The disposal of low-level radioactive wastes may seem like a minor concern among medicine's worries. But consider these facts:

■ Twenty-five percent to 30 percent of all low-level radioactive wastes produced in the US results directly from medical uses.

■ About 120 million nuclear medicine procedures contribute annually to low-level radioactive waste production.

■ Research is a significant contributor to low-level radioactive waste production. For example, radioisotopes are used in the development and evaluation of about 90 percent of all new drugs.

Universities, medical schools, hospitals, laboratories and medical practices are among the producers of low-level radioactive wastes. Their activities clearly benefit individual patients and society as a whole.

Then why is disposal of radioactive wastes a problem?

Actually, disposal has long been more a political than a public health problem. In the 1960s, six licensed commercial facilities received wastes from across the country. After three of these facilities closed, opposition developed in the three remaining host states on the grounds that they should not be burdened with the disposal needs of the entire nation.

In response, Congress passed the Low Level Radioactive Wastes Policy Act in 1980. Under this bill, each state would eventually become responsible for disposal of radioactive wastes generated within its boundaries. The act recommended that states participate in regional groupings or compacts to improve the cost-effectiveness of disposal facilities. It also stated that any regional facility could exclude wastes from outside its region after January 1, 1986.

For the next five years, states moved to negotiate compacts and sign the necessary agreements. The difficulty in locating and gaining approval for disposal sites slowed progress. Remote sites might satisfy public sentiment, but their remote-

ness complicated disposal convenience and cost.

By 1985, it was clear that states would not meet the 1986 deadline. Congress responded with amendments to the Wastes Policy Act, extending the deadline to January 1, 1993. On that date, the three existing commercial sites — located in Beatty, Nevada; Richland, Washington; and Barnwell, South Carolina — will be closed to outsiders.

State negotiations have proceeded since 1985. Yet selecting a disposal site and preparing to operate a facility involves a complicated series of steps. In its 1988 information report ("Low-level Radioactive Wastes," August 4, 1989, Vol. 26, No. 5, pp. 669-674, *Journal of the American Medical Association*), the AMA Council on Scientific Affairs said those steps include legislation, government oversight, public participation, financing, engineering, supervision, surveillance and quality control. Few states are far along in this process and fewer still are expected to meet the 1993 deadline.

Physicians can play a key role in helping their states develop acceptable disposal facilities for low-level radioactive wastes. Their medical training can provide an informed perspective on the personal and public health risks related to waste disposal. But more importantly, they can describe the beneficial uses of procedures that produce radioactive wastes and how these uses will be compromised if disposal sites for the wastes are unavailable.

Consider becoming involved in efforts to establish disposal facilities. First, contact representatives of your state's radiation control program or health agency. Arrange to meet with them, determine whether your state is involved in a compact, and offer your support. Encourage these representatives to consider what will be done if a disposal site is not available by January 1, 1993. Stress the need to develop one or more storage sites for low-level wastes as an intermediate measure until a disposal site becomes available.

Secondly, encourage your medical society's public health or environmental

health committee to become involved. Pass policy regarding the disposal of low-level radioactive wastes and then promote it. Through lobbying efforts or by working with public health authorities, the medical society can influence disposal facility plans.

Finally, physicians can help persuade their patients, the media and community groups that radioactive materials can be beneficial. Seek opportunities to lead discussions in classrooms or speak to public audiences.

For further information contact: The Division of Biomedical Science (J. Loeb, PhD, Director), American Medical Association, 515 North State Street, Chicago, Illinois 60610; (312) 464-5456. ■

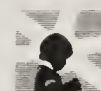
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MEDICAL NEWSFRONTS

INDEX

Women who find benign breast lump through self-exam likely to quit self-exams, U-M reports	9	Beaumont seeks volunteers for weight loss study	11
MSU uses light therapy to treat seasonal affective disorder (SAD)	9	Michigan kids to gain health care coverage	11
Kellogg awards \$166,000 to Project HOW to aid Detroit's uninsured	10	MSU acquires new weapon in battle against cancer	11
Disabled will get helping hand from robotics, U-M says	10	State adds Northern Michigan office to regulate health facilities	12
		MDPH begins SEARCH study	12

Women who find benign breast lump through self-exam likely to quit self-exams, U-M reports

Women who find a benign breast lump themselves are three times more likely to quit performing breast self-examinations than those who have never found a lump, according to a University of Michigan study.

"On the other hand, women who have had a lump discovered by a physician, nurse or mammogram are twice as likely to start doing self-exams, or to do them more often, as women who have never had a lump, says Nancy K. Janz, assistant research scientist, and Marshall H. Becker, professor of health behavior and health education. Both are researchers at the U-M School of Public Health.

The researchers explain the contradictory behavior of the self-discovered group this way: "Although a negative biopsy is clearly good news, the biopsy is accompanied by some stress, discomfort, cost and inconvenience. Women who

find the begin lump themselves sometimes feel that they triggered the unpleasantness by their own actions...so almost unconsciously, some may decide not to chance such an experience again. Women who have had the lump discovered by someone else don't feel responsible for what followed."

Physicians and nurses must be alert to this behavior pattern and strongly encourage patients to continue self-exams, the researchers say. "Women who practice breast self-examination regularly are more likely to detect lumps in the early states of development and have a good chance for a favorable medical outcome." Only about 30 percent of women in the United States conduct breast self-examinations regularly.

An ideal time for doctors and nurses to reinforce the need to continue breast-self examination is when they discuss biopsy results with the patient, Janz and Becker say. "However, only 52 percent of the self-discovered group and 57 percent of the health-care discovered group said the doctor or nurse had urged them to continue. The percentages should be much

higher."

A key predictor of whether a woman does breast self-examination is confidence in her ability to do it properly, the U-M researchers add.

"Ironically, we found that some women who practiced self-examination occasionally or regularly, but who had failed to find the lump themselves, were inclined to quit their self-exams altogether after the biopsy. They lost confidence in their ability to do it.

"In those cases," they stress, "it is critical for the physician or nurse to emphasize that the lump was small or not palpable and that the woman should not feel like a failure."

There were 655 subjects in the U-M study. Eighty-three women discovered a lump through self-examination; 179 of the women had a lump discovered by a doctor, nurse or mammogram; and 393 were controls who had no history of breast lumps.

The researchers also found that younger women who smoked and were not overweight were more likely to perform self-examinations. "Smokers may be more concerned that they are at risk, so they may be more likely to do the self-exams," the researchers explained.

MSU uses light therapy to treat seasonal affective disorder (SAD)

Doctor Robert Bielski's eyes light up as he tells the story of a woman who suffered from depression so bad she couldn't even get out of bed without help. But after about a week of something called "light therapy" she's practically as good as new.

The woman, a victim of "seasonal affective disorder," or, appropriately enough, SAD, is one of many success

stories coming to light at a Michigan State University clinic which specializes in the treatment of the disorder.

"We feel we've been very successful," said Doctor Bielski, director of the MSU Affective Disorders Program and an associate professor of psychiatry. "About 70 percent of the people we've treated have had a very clear response to light therapy."

SAD sufferers experience a full range of depression symptoms, including a loss of energy and increased appetite. And while these are common among many people during the winter months, SAD victims take it to the extreme.

"I know that in the winter I tend to be a bit less energetic and maybe put on a few pounds," Doctor Bielski said. "But it doesn't bother me. It doesn't get in my way. At the other end of the spectrum there are people who literally cannot get up, get out of bed and do what they need to do."

Light therapy treatment consists of two hours of sitting before a bank of lights. Patients are exposed to the full spectrum of light (that is, the entire spectrum of color).

However, Doctor Bielski said there is evidence that more limited spectrum of light can work just as well.

"One of the research projects we are working on now is to determine the proper wavelength of light," he said. "We want to make sure we're not exposing people to wavelengths they don't need.

"There is evidence that ultraviolet light can damage skin and eyes and we would like to exclude that wavelength if possible and still get therapeutic benefits."

The other question Doctor Bielski and colleagues are trying to answer is, why?

"We're trying to better understand what the mechanism of action of light therapy is," he said. "In other words, why does it work?"

Continued on page 10

Continued from previous page

Michigan residents may be especially prone to the dangers of SAD, according to Doctor Bielski. The state is the third worst in the country in the percentage of available sunlight between September and May.

For information on the MSU Affective Disorders Program, call (517) 353-3070.

Kellogg awards \$166,000 to Project HOW to aid Detroit's uninsured

The Metropolitan Detroit Foundation's Project Health on Wheels (HOW), will continue to provide free medical care to uninsured residents through a \$166,094 grant from the Kellogg Foundation.

"This grant came at a time when we really needed additional funds to keep the project alive," said Annette G. Smothers, HOW project director. "It has provided the financial support that we need to keep rolling for the next three years."

Money from the grant has been allocated for medical supplies, office expenses, a computer and data base, travel costs and office personnel. "The physicians, nurses, and social workers on site for Project HOW volunteer their time and services. In return, we provide insurance to cover them," said Smothers.

A part-time office assistant and full-time director are paid to administer the project.

"There is such a great demand for health care in the Detroit area, and so many of those in need do not have any kind of health insurance," said Richard Henderson, MD, co-medical director and founder of Project How. "According to Detroit Neighborhood Services there are an estimated 110,000 medically indigent persons in

Detroit. Project HOW is just one answer to this serious problem."

Project HOW began as an idea of Doctor Henderson's and later became a joint effort between the Wayne County Medical Society and the Detroit Medical Society. Representatives from each society sit on Project HOW's governing board. The Metropolitan Detroit Foundation for Health Education serves as the fiduciary for the project.

Currently, there are five Project HOW sites in Detroit. Project HOW is the only medical program of its kind in Detroit. It was designed to serve the city's increasing population of uninsured persons. Patients without medical insurance are seen by medical doctors and registered nurses for non-emergency medical concerns free of charge. Appointments are made at the Project HOW office, housed at the Wayne County Medical Society headquarters, (313) 567-1640. Referrals are made on site for patients who need care by a specialist. These services are also provided without cost to the patient.

Disabled will get helping hand from robotics, U-M says

Researchers at the University of Michigan are making great strides with robotics that will some day make it easier for disabled persons to live independently.

The "Mobile Rehabilitation Robot Project," is designed to develop a mobile robot for physically impaired people to perform chores at home or work or in an institutionalized setting.

While stationary robot workstations are beginning to appear in the homes and workplaces of disabled persons, having a mobile robot to aid a disabled person is still

Physicians in the News

Fred Severyn, MD, has been promoted to vice president and corporate medical director of Blue Cross and Blue Shield of Michigan (BCBSM). Doctor Severyn joined BCBSM in November, 1985, and most recently served as senior medical director of provider relations. He practiced obstetrics and gynecology in Southgate and Wyandotte for 22 years prior to joining BCBSM. Doctor Severyn, 58, holds a degree in medicine from Stritch School of Medicine, Loyola University, Chicago. He completed his residency at Oakwood Hospital, Dearborn, and interned at Detroit Receiving Hospital in The Detroit Medical Center.

John Chimoskey, MD, physiology professor and interim chairman, MSU College of Human Medicine, has been awarded a Fulbright award to lecture in Brazil for the 1990-91 academic year. His lecture tour is from August 3 to October 3 and takes him to Manaus, Recife, Salvador and Rio De Janeiro.

Carla A. Cook, MD, Almont, has been named a fellow of the American College of Radiology (ACR). Selected for her outstanding contributions to the field of radiology, Doctor Cook was named one of 131 new fellows by the College's Board of Chancellors, during ceremonies at the recent ACR annual meeting in Nashville, TN.

Kenneth Pitts, MD, is the new chief of psychiatry at

Annapolis Hospital-Westland Center, Westland. Doctor Pitts, also a clinical associate professor at Wayne State University School of Medicine, will head a team of psychiatrists, psychologists, sociologists, therapists, counselors and other specialists in mental health care and chemical dependency at the Westland Center.

Lanny Johnson, MD, an international innovator in the art and science of medicine, was recognized for his "unselfish contributions, friendship and public trust," by Ingham Medical Center, Lansing, at its 1990 Healthcare Leadership Awards Ceremony held in November. Doctor Johnson is an arthroscopic surgeon.



The Michigan Society of Internal Medicine elected the following new officers at its Annual Meeting: **John R. Maurer, MD**, president; **Vernon E. Wendt, MD**, president-elect; **Catherine Upton, MD**, secretary-treasurer; and **Caroline Kimmel**, executive secretary.

Continued on page 11

Continued from previous page

years away, but the possibilities continue to grow.

"We want this robot to either lead or follow a person without the individual having to give conscious demands to the robot," said Simon P. Levine, PhD, director of the Rehabilitation Engineering Program at the U-M Medical Center. "That means the robot has to uniquely identify the user or companion amongst all the other obstacles in its environment, including other people."

Levine is part of a team that includes Johann Borenstein, PhD, and Yoram Koren, PhD, from the U-M Department of Mechanical Engineering. The team is developing a robot that can move through an environment while avoiding obstacles and be able to carry a variety of environmental manipulators, such as a robotic arm.

The project's goal is to eliminate the need for the user to guide the robot with a specific language, which can be difficult and burdensome.

"If you are going to another room and you want your robot to follow you, you certainly don't want to spend your time giving commands — left, right, faster, slower. You would like the robot to follow at a safe distance but without losing you or without you having to exert any conscious control," said Levine, associate professor of physical medicine and rehabilitation.

Borenstein and Koren developed the obstacle avoidance technology that allows the robot to safely navigate through unknown environments.

The initial research was funded by \$70,000 from the Medical Center and the College of Engineering. The research team is now in the pilot year of a three-year, \$110,000 grant from the Veterans Administration Rehabilitation Research and Development Service in Washington, DC. By the third year, the team hopes to begin clinical trials for the robot.

In the meantime, research and development continues to integrate obstacle avoidance, path planning and companion tracking in a robot.

Beaumont seeks volunteers for weight loss study

The William Beaumont Hospital Clinics of Preventive and Nutritional Medicine are seeking volunteers for a four-month weight loss study.

The research study is to evaluate the effectiveness of a new investigational drug used in combination with extensive dietary counseling.

Participants may be women of non-childbearing potential or men, ages 18 to 65 years.

For more information on the study, call (313) 645-8158.

Michigan kids to gain health care coverage

Over 12,000 Michigan children who lack health insurance will have coverage next year under a demonstration project approved by the Health Care Financing Administration (HCFA).

Michigan will receive a grant of up to \$6.6 million to establish the **Michigan Child Caring Program**, a unique and innovative approach to expand health care coverage through a public-private partnership between the Department of Social Services and Blue Cross and Blue Shield of Michigan over the next three years. The focus of the program is on children who are not now eligible for Medicaid and whose parents make up a growing share of American's working poor.

"Until we address the problem of universal access to health care for all Americans efforts like this one, that stress improving the current delivery of health care services for

children, are critical," said Senator Donald Riegle, chairman of the Finance Subcommittee on Health Care for Families and the Uninsured.

The funds were approved as part of a demonstration project designed to close the gaps which leave many children without access to health care. Those eligible include children through age 18 who are not eligible for mainstream Medicaid in households with incomes up to 185 percent of the poverty level. Pregnant women and infants to age one, up to 185 percent of poverty are currently covered by Michigan Medicaid. It is estimated there are some 300,000 uninsured children in Michigan today.

Last year, Senator Riegle co-authored a provision of the Maternal and Child Health Care Package that established authority for such demonstration projects nationwide.

MSU acquires new weapon in battle against cancer

A revolutionary system which will help health care professionals diagnose breast cancer faster, less expensively, and with much less discomfort to women has been obtained by Michigan State University.

The system, developed by Sweden's Karolinska Institute, brings together the medical specialties of radiology and pathology in the use of a unique machine called the "Mammothest." The machine doesn't replace the mammogram, but provides a fast, nearly painless procedure for testing whether an abnormality on a mammogram is cancerous.

"When there is a concern, the most common thing to do is tell the patient to come back in six months for a repeat mammogram, or to schedule a surgical biopsy in two to three weeks," said E. James

Potchen, MD, chairperson of MSU's Department of Radiology. "You either put a woman through 21 days of real concern or six months of heightened anxiety."

The Mammothest, by using two "stereo" X-ray exposures (taken at 15 degree angles), gives the radiologist a highly accurate location of the lesion. Then, using an extremely fine needle, the radiologist removes a few cells from the lesion. The cells are then tested to determine if they are cancerous.

"The advantage to this is we are able to get the results immediately, or at least the same day," said Janet Osuch, MD, MSU associate professor of surgery. "And, we don't have to make an incision."

It is also much less expensive than a surgical biopsy, she said. The procedure costs between \$400-\$500, compared to around \$1,600 for the surgical biopsy.

In addition, because a biopsy removes a small portion of the breast it can be potentially disfiguring. The Mammothest removes just a few cells, and does it relatively pain-free.

"I've had patients compare it to having blood drawn," said Doctor Osuch. Most surgical biopsies will no longer be needed, said Doctor Potchen, because most abnormalities detected on a mammogram are non-cancerous. On the average, for every nine surgical biopsies of the breast done in the US, there are eight normals and one cancer.

"Previously, the many surgical biopsies were necessary to discover and cure the earliest breast cancers," he said. "At Karolinska, when nine surgical biopsies are done, they find eight cancers and one normal. They need fewer surgical biopsies to diagnose cancer."

The Karolinska Institute, home of the Nobel Prize, is considered a world leader in breast cancer diagnosis and treatment. Recently, the MSU

Continued on page 12

Continued from page 10

Department of Radiology and the Karolinska breast cancer diagnosis group entered into a joint agreement, establishing a "sister institution" relationship.

The agreement states that the "joint venture will seek to transfer technology, disseminate knowledge and engage in selected areas of clinical and basic research directed toward decreasing mortality from breast cancer."

Doctor Potchen said the Karolinska system of breast cancer control, which incorporates use of the Mammotest machine, is the world's most successful approach to decreasing surgical biopsy while increasing the cure rate of early breast cancer. He said one reason for entering into the joint venture with the institute is to bring this system to the United States.

"We are importing their program to MSU to demonstrate to the American people an alternative to breast cancer management," he said. "This is a program which could change our approach to breast cancer."

Presently, there are only 11 Mammotest devices in the US. MSU's device is housed in the Department of Radiology in the Clinical Center.

State adds N. Michigan office to regulate health facilities

The Michigan Department of Public Health (MDPH) has opened a new district office in Gaylord to regulate and oversee facilities in Northern Michigan. A 10-person inspection team will work from the office located in the Alpine Executive Center, 400 Main Street, Suite 108.

The team will be responsible for licensing and/or certification of hospitals, psychiatric hospitals, nursing homes, homes for the aged, dialysis units, ambulatory surgical care

facilities and other health facilities in Upper Peninsula and Lower Peninsula counties north of the Benzie-Alcona tier.

For more information, contact Evelyn Jones, Division of Health Facility Licensing and Certification, MDPH, at (517) 335-8472.

MDPH begins SEARCH study

The Michigan Department of Public Health's AIDS Surveillance Unit has begun the fieldwork portion of its Innovative AIDS Surveillance study, titled Surveillance Evaluation of AIDS Reporting in Health Care Settings, or SEARCH. Medical record reviews will be completed at Michigan hospitals and outpatient facilities. Approximately 100 randomly-selected physicians (statewide) will be mailed a full description of this project and asked to participate.

This study, funded by the Centers for Disease Control and designed in collaboration with seven other project sites, will compare medical databases in 1) estimating the completeness of AIDS case reporting (and its implications for MDPH AIDS surveillance), 2) identifying HIV-related morbidity, and 3) assessing value of ICD-9 discharge codes in predicting AIDS or HIV infection.

All occurrences of certain opportunistic infections coded on three 1988 statewide medical records databases were identified and compared to the MDPH AIDS Case Registry. Randomly selected records will be validated through medical record review to identify AIDS cases, HIV-infection not AIDS, opportunistic infections not due to HIV, and coding errors.

Questions concerning this project may be directed to Patricia Starr, study coordinator, or to James Kent, AIDS epidemiologist, at (517) 335-8165. ■

Michigan State Medical Society

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or _____
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on _____
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DATE _____ 1990. _____
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LIVING WILLS IN MICHIGAN

Why the time is right

By Howard Brody, MD

This issue of *Michigan Medicine* marks a turning point in MSMS posture regarding advance directives ("living wills"). For many years, MSMS has discussed the issue and has supported legislation, more or less behind the scenes. We are now involved in a more proactive stance, trying to encourage more discussion and wider use of these devices, whether or not legislation is enacted.

In this article I will: 1) review some basic terms and ethical principles; 2) recount the deliberations of the MSMS Committee on Bioethics on this topic; and 3) indicate why the time is now ripe for more action by Michigan physicians.

Definitions and principles

The vague and metaphorical nature of the popular term "living will" makes it desirable to use the more correct and technical term, *advance directive*. An advance directive is a provision for allowing a patient who is now rational and competent, and who can anticipate medical decisions which might have to be made later, to record those wishes so that they can be acted upon even if he or she later becomes incompetent. The ethical principle involved is respect for patient autonomy or the right of self-determination — a basic notion of respect for other persons, which ought not to cease just because the other person is now unable to participate in a decision.

The general concept of advance directives contains two subcategories, *document approaches* and *agent approaches*. The first records the actual wishes of the person in writing; the second designates a spokesperson whom the person wishes to act on his or her behalf. The document approach is what is most commonly referred to by the term "living will." The legal mechanism by which the agent approach is generally recognized is "durable power of attorney." (A common misunder-

standing is that one's agent under "durable power of attorney" must be a lawyer; actually it could be any competent adult.)

The two approaches are not mutually exclusive and could readily be combined, completely or partially. The same individual may both fill out a "living will" and execute a durable power of attorney. A "living will" could indicate the name of a person whom the patient wishes to be consulted by the physician regarding any portions of the directive that are vague or ambiguous. And a durable power of attorney could contain a space for the person to indicate his or her wishes, for the agent to consult later.

It is important to emphasize that the linkage of the notion of advance directives with *refusing* life-prolonging treatment mirrors current public opinion and not the advance directive concept itself. In theory, a patient could use an advance directive to request additional, aggressive treatment. That advance directives are not more commonly used that way reflects what most patients today are most concerned about, as will be discussed below.

Debates and deliberations

The MSMS Committee on Bioethics

has been addressing the issues of advance directives since it was formed in the early 1980s. State Representative David Hollister had already introduced a durable power of attorney-type bill, and MSMS has supported this legislation consistently. Rep. Hollister's task force had heard advice in the late 1970s which favored the durable power of attorney approach over the "living will" and hence the legislation took that form.

When a "living will" bill was subsequently introduced by Representative Perry Bullard, the Committee on Bioethics was initially somewhat more skeptical. The medical-ethical literature has generally tended to favor durable power over "living wills." The most standard form of "living will" usually states something to the effect, "If I am irreversibly or terminally ill, I do not wish to receive heroic or extraordinary treatments to prolong my life." Many of the terms included here are very difficult to interpret in practice. Moreover, in order for an individual to be more specific, one would have to be able to predict with great accuracy and detail the precise illness the patient

Continued on next page

will be suffering from when the decision must be made, and what treatments are then being proposed — generally an unrealistic feat of clairvoyance.

Subsequently the Committee on Bioethics has become more favorably disposed toward the document approach, especially when it can be combined with the agent approach. A theoretical reason for this change is that the weaknesses of each approach are compensated for by the strengths of the other. The primary criticism of “living wills,” their inherent vagueness, can be mitigated by having a spokesperson to whom the physician can explain the exact medical circumstances at the time of decision-making, and who can help the physician to understand how the patient would have wanted his document interpreted. The main criticism of the durable power approach is that the agent may make a decision which varies from that which would have been made by the patient; but that chance is minimized if the patient has left some written instructions for the agent. Thus the combined approach may be superior to either taken singly.

A practical reason for the Committee on Bioethics’ modified view is the leadership taken by the Genesee County Medical Society in drawing up and distributing a version of a combined document (which has been reproduced on page 23 in this issue). Reports have suggested that this document has proven useful to both patients and physicians and that no significant problems have been encountered with its use.

The events of 1990

While MSMS has supported legislation on advance directives and has provided information and input when requested, the time is now ripe for a much more aggressive and pro-active campaign to encourage Michigan physicians and citizens to make use of advance directives and to become better educated about them. The *Cruzan* decision of the US Supreme Court in June, and Doctor Jack Kevorkian’s widely publicized assistance in the death of Janet Adkins by “suicide machine,” point out the need for a more active posture.

While the *Cruzan* decision upheld the Missouri legal standard which would require “clear and convincing evidence” of a patient’s *expressed* wishes before a family member can order the removal of life-prolonging treatment in irreversible illness,

Michigan and other states are not required to accept the same strict standard of evidence. Nevertheless, almost all commentaries that appeared in the press after *Cruzan* stressed the fact that even in states like Missouri, a written advance directive would be viewed as “clear and convincing evidence” of the sort needed. The Supreme Court did not directly address durable power of attorney, but the opinions hint strongly that a majority of the court would have found a durable power of attorney “clear and convincing” as well. Therefore the *Cruzan* ruling strongly stimulated public interest in advance directives, especially “living wills,” and Rep. Hollister’s and Bullard’s offices were swamped with requests for copies of their proposed documents.

The case of Doctor Kevorkian raises a tangle of ethical problems. When, if ever, and under what circumstances a physician might be morally justified in assisting a patient’s suicide is a problem that defies a quick and precise statement of policy; there is ample evidence that physicians are divided amongst themselves on this issue.

When faced with a complex ethical problem which will inevitably require much more dialogue and debate before it could be resolved, we might ask whether there are uncontroversial aspects of the problem upon which we can find ready agreement. And one such aspect would seem to be that we ought to do everything possible to decrease the number of patients who might feel driven to request a physician-assisted death.

Public needs and physician responses

We must at this point turn to opinion polls and other measures of public sentiment for guidance, and in 1990 these measures tell a convincing story. Relatively few patients are afraid of the Doctor Kevorkians who might act to hasten their demise; the vast majority are much more afraid of the unthinking and inappropriate application of lifesaving medical technology which would prolong their dying with suffering and indignity. And, in particular, patients seem to fear a loss of control over their own dying process — hence, any measure that reassures people about retaining some reasonable degree of control, and assures them of the right to refuse technologies which they would find unduly burdensome. The Committee on Bioethics has identified three rather uncontroversial means to do this:

1) The physician can be fully aware of

hospice programs and other services that focus upon relief of pain and suffering in the dying process. If not personally familiar with these techniques, the physician can pledge to refer or consult with these services in caring for seriously and terminally ill patients.

2) The physician can emphasize in dialogue with patients that he or she recognizes the legal and moral duty to respect patients’ choices, including the refusal of life-sustaining treatment, so long as the patient is competent.

3) The physician can become informed about alternative means of executing advance directives, recommend that patients consider these options, and stand ready to participate helpfully in the process.

These measures will not by themselves evade the complicated long-term issues of assisted suicide and assisted death. Janet Adkins, as a member of the Hemlock Society in Oregon, doubtless knew about all these options, and yet still sought an early death as preferable to the slow progression of her Alzheimer’s disease. But these measures represent a *minimum* which Michigan physicians ought to be prepared to promise their patients; to do less is to say that we are more wedded to our technology than to the rights and needs of our patients.

In talking to hospital staff in Michigan and elsewhere, I still hear anecdotal reports about “physicians who will never write a DNR order” or “physicians who refuse to recognize living wills.” In the past we have tended to react sympathetically to those of our colleagues who could “never give up,” or who were religiously or ideologically motivated always to try to prolong life at whatever cost. In particular, I would urge that the time is past when we can afford to allow resistance in this area to go unchallenged. I fear that the time for making such allowances is past; when some physicians refuse to respect properly recorded patient directives, all of us lose credibility as advocates for our patients.

Physicians who have trouble with the advance directive notion, or with stopping life-prolonging treatment, must no longer involve unwilling patients and families in the name of their own emotional or ideological stances. At the very least, they should inform patients of their positions at the outset of the therapeutic relationship, so that patients would be free to seek another physician. They should also be aware that lawsuits against facilities which force unconsented-to life-prolonging treatment on patients now appear to

Continued on page 19



Dr. Holwick outside of hospital where she practices as a civilian traumatologist.



Dr. Holwick in operating room at Letterman Army Medical Center.

JANN L. HOLWICK, M.D.

General and Trauma Surgeon.
Captain, U.S. Army Reserve.

EDUCATION University of Southern California, B.S.;
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California.

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Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon.

Those reported include:

- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, serum-sickness-like reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis,

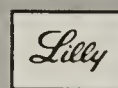
and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology.

- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
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Continued from page 16

be on the rise; so "defensive medicine" can no longer be an excuse for *always* employing life-prolonging technology.

Advance directives: The helpful physician

How can physicians help patients specifically with advance directives, besides knowing about the possible documents and recommending that interested patients explore these options?

1) Offer to review a draft "living will" with the patient. Help the patient to anticipate what sorts of treatment decisions are likely to come up in practice, and what sorts of directives will most aid the physician.

2) Emphasize communication. Some advance directives have been overridden by family disagreements. Tell patients how important it is to discuss their views in advance with other family members, to prevent later surprises.

3) Try to encourage flexible directives where appropriate. If the patient is refusing intubation, is he adequately aware that under some circumstances, intubation and ventilation could produce a complete reversal of the medical problem and the return to a reasonable quality of life? If you are going to have problems going along with the patient's wishes, be sure your concerns are voiced early, when the patient is still competent and can participate in further dialogue.

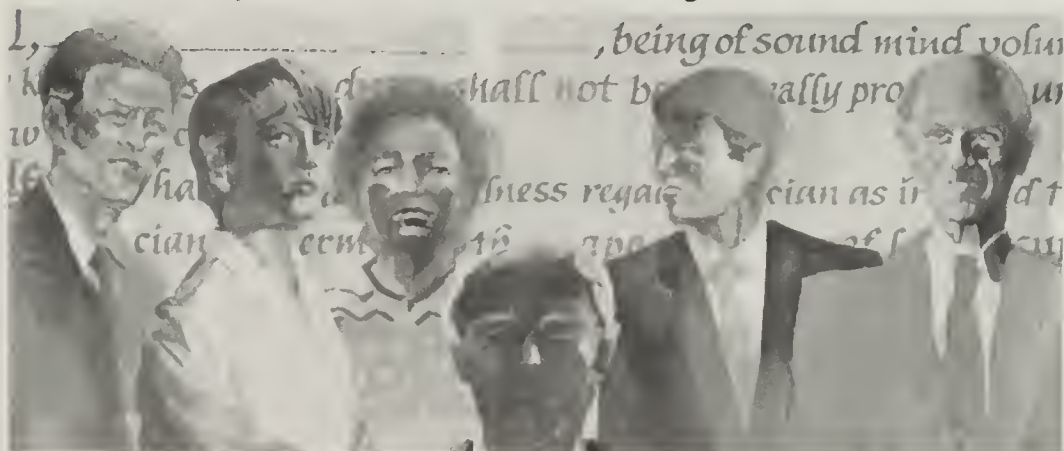
4) Make it a habit, especially when you do not know the patient well, to ask on hospital admission whether the patient has ever executed an advance directive. This need not be threatening to the patient, and need not imply that one is expecting a fatal outcome — it can be raised simply as a routine request to be sure that the patient's own wishes are respected. A California hospital reported recently that doing this for all admissions over several months led to the discovery of two advance directives that had been unknown to the physician.

The MSMS Committee on Bioethics believes that it is time that all of us became leaders, rather than mere followers, in the advance directives movement. Study this issue of *Michigan Medicine* carefully to see how you can help. ■

Doctor Brody is professor of family practice and director of the Center for Ethics and Humanities in the Life Sciences at Michigan State University. He also is chairman of the MSMS Committee on Bioethics.

LEGAL CONSIDERATIONS OF LIVING WILLS

By Richard D. Weber, MSMS Legal Counsel



Current events have placed living wills as a major health care issue for both society and the medical profession. The following article will briefly describe what living wills are and then discuss their legal validity, the need for legislation and the essential provisions for the document.

What living wills are

A living will is a relatively simple document by which a person directs medical treatment preferences in the event that person is unable to make medical decisions at a later date. Typically, a living will authorizes the withholding or withdrawal of life-sustaining treatment. It is triggered by the physician's decision that the patient is in a terminal condition and has no reasonable hope of recovery. Often a living will includes a "durable power of attorney." This is simply an authorization for another person to make medical care decisions on behalf of a patient when that patient is unable to do so.

Legal validity

The recent Supreme Court decision in *Cruzan v Director, Missouri Department of Health*, 110 Sup. Ct. 2841 (1990) has caused considerable interest in living wills. In *Cruzan*, a young woman was left comatose by a car accident. Her family requested removal of feeding tubes and submitted evidence in court that she told her friend that she would not want her life to be prolonged under such circumstances. The Missouri Supreme Court refused to allow the tubes to be removed, holding that the Missouri statute contained a strong policy favoring preservation of life, which required clear and convincing evi-

dence of the patient's wishes. The US Supreme Court upheld the Missouri court decision.

The sole issue before the Supreme Court was whether the US Constitution forbids a state from establishing an evidentiary standard of "clear and convincing evidence" of the wishes of an incompetent person before life support may be withdrawn. The Court held that the Constitution does not forbid a state from establishing such a rule of law. The US Supreme Court did not decide the wisdom of the Missouri law. It simply decided that the US Constitution does not preclude a state from making such a law.

Significantly, the Supreme Court in *Cruzan* stated that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment. This pronouncement by the nation's highest court creating a constitutional right supports the legal validity of a living will. As a constitutional right, no state could deny a competent patient the right to refuse unwanted medical treatment. Therefore, no state could refuse to recognize a living will properly executed by a competent person which clearly expresses the patient's wishes. The *Cruzan* decision encourages the use of living wills as the best evidence of the patient's wishes. The Supreme Court has put an end to the legal debate as to whether or not a competent person could make medical care decisions, notwithstanding the lack of state legislative or judicial authority on the issue.

Need for legislation

At last count, at least 40 states have enacted laws legalizing living wills. Unfortunately, Michigan is not among them. Mich-

Continued on next page

igan has no living will statute or appellate cases supporting living wills. Legislation has been and continues to be debated in the Michigan legislature. The proposed Michigan Medical Self-Determination Act would legalize living wills. House Bill 4174 would allow anyone 18 years of age or older who is of sound mind to record their wishes regarding medical care in the event he/she becomes terminally ill or permanently unconscious and can no longer make medical treatment decisions. Companion legislation is also being debated in the Michigan legislature which would establish a durable power of attorney. House Bill 4016 would permit the appointment of a "patient advocate" for adults unable to make health care decisions.

If a person has a constitutional right to exercise medical care decisions by way of a living will, why is legislation in Michigan needed? The reason for such legislation is to provide a clearly defined mechanism for a patient to express his or her wishes which can be relied upon by the physician and family. Such legislation is needed to provide statutory immunity for the physi-

cian and related health care personnel who participate in implementing the patient's decision pursuant to the terms of a living will. The physician and other health care professionals must be protected against later arguments that the patient revoked the living will, that it was a forgery or that the patient signed it without sound mind. In the case of a testamentary will, the legitimacy of the document is determined by the probate court. In the context of a living will, however, the determination must be made by the physician. It is essential that the physician who acts in good faith pursuant to the terms of a duly executed living will not be subjected to either civil or criminal liability. The most effective way to accomplish this objective is through legislation. Hopefully, the legislature will now act in view of the constitutional rights enunciated by the Supreme Court in *Cruzan*.

Essential provisions

Without statutory direction there is no set form for living wills. Nevertheless, there are certain basic provisions which should be included: (1) a statement that

the declarant is of sound mind; (2) a description of the treatment the declarant desires or does not desire; (3) a description of the triggering event which renders the declarant unable to make treatment decisions, such as terminal illness or permanent unconsciousness; (4) a provision that the physicians and other medical personnel involved in carrying out the terms of the living will shall be immune from civil and criminal liability; and (5) a statement that the living will is revocable at any time. In addition, a durable power of attorney, which is optional, should be offered as a part of any such document. The document should be dated and signed by two disinterested witnesses.

Although Michigan has no law, either legislative or judicial, legalizing living wills, their legal effect is now clear. They are the best means for a person to exercise his/her constitutional right. Even absent needed legislation, a living will is a legally valid and significant document in Michigan. ■

Dick Weber is an attorney with Kerr, Russell & Weber, Detroit, and serves as legal counsel for MSMS.



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Patient capability to participate in his/her health care decisions vitally important

By John V. Hartline, MD

Answering the question as to a patient's capability to participate in health care decisions is vitally important regarding consent to and/or refusal of treatment. There is a need for guidelines to help caregivers assess the patient's decision-making ability in such matters.

The process for decision-making for patients who may have some impairment in capacity to participate in their health care decisions is particularly problematic. For fully capable patients and for incapable patients, guidelines have been reasonably well established and will not be discussed in great detail. The major focus of this article will be on the individual who might be capable and who might want to participate. How do physicians and others close to the patient assess the patient's role in selection of options for health care?

Patients with full decision-making capacity

The patient who is mentally competent generally has the right to consent to or to refuse treatment offered. This includes life-sustaining and/or life prolonging treatment as well as other treatments. This right may be limited only under unusual circumstances when another individual, such as a dependent child, would be harmed.

Patients with some impairment in decision-making capacity

The degree to which the patient can or should contribute to decision-making when partially impaired is a much more problematic issue. Individuals should be considered capable of making their own health care choices unless there is convincing evidence to the contrary. The capacity to make decisions regarding health care alternatives often persists in individ-

uals who no longer are capable of managing all issues in their lives, such as financial.

Capacity to make health care decisions is not defined by agreement (or disagreement) with recommendations made by the physician. Physicians have the obligation to provide the patient with information regarding diagnosis, treatment alternatives and recommended treatment, expected consequences of treatment (and non-treatment), and long-term prognosis.

The following characteristics of the patient can be considered when evaluating the capacity of an individual to participate in a health care decision:

1. Ability to communicate and maintain a consistent choice.
2. Ability to understand information relevant to the decision to be made.
3. Appreciation of the current situation and its consequences.
4. Ability to use rational processes to compare the benefits and risks of various treatment options.

When an individual's ability to make health care choices is uncertain, consultation with other experienced professionals can be helpful. Special education experts with skills in communicating with persons with mental retardation or with persons unable to speak or hear can enhance patient understanding and participation. Advocates for patients with disabilities can help make us aware of non-medical/surgical alternatives in some instances.

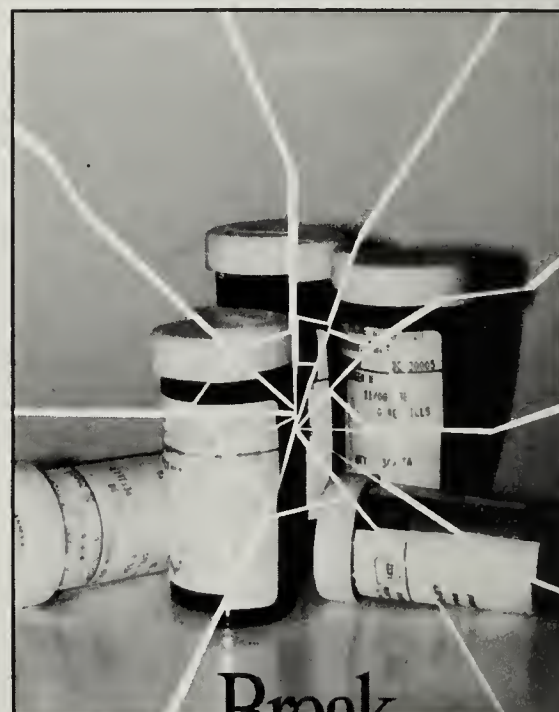
Some decisions may imply a need for consultation. Physicians may be very vulnerable acting without consultation when the recommended therapy is especially invasive or associated with significant risks, research-oriented or innovative, or associated with areas of great societal concern or controversy.

A hospital ethics committee may assist in determining criteria to be applied in a given situation, in exploring the range of ethically appropriate options, and in defining the appropriate decision-maker, either patient or surrogate. Only when the question remains unresolved or significant discordance exists should a court's determination be sought.

Patients lacking decision-making capacity

To the degree possible, decisions for the formerly competent and capable individual should be made in accordance with the patient's wishes and by whomever the patient had designated. Decisions being made for individuals unable and never having been capable of deciding should focus on alternatives most serving the patient's best interests. The decision-making process for incompetent patients has been discussed in detail by the President's Commission and criteria for determining what treatments can or should be foregone have been promulgated. ■

Doctor Hartline is a member of the MSMS Committee on Bioethics.



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Genesee County Medical Society develops living will document

On the following page appears a copy of a living will document recently prepared by legal counsel for the Genesee County Medical Society.

Upon receiving a copy of the living will document, Genesee County Medical Society members were advised to show their patients a copy of the living will document "should your patient initiate a discussion with you indicating the desire to create a living will." Members were further instructed to do the following: "If your patient desires to sign such a form, it is our suggestion that you advise the patient to sign more than one form in the presence of two disinterested witnesses who should sign in the place provided. A signed copy should be returned to you to be placed in the patient's medical records. Other signed copies should be delivered to the patient's attorney (if he or she has one) and, most definitely, to patient's closest living relative and/or a caring person familiar with the patient's daily needs. You should point out to your patient that he/she should designate someone to act on his/her behalf in the event the patient is incapacitated. A designation clause form is included at the bottom of the living will declaration for this purpose."

Michigan Medicine presents a copy of this living will document as merely one example of the kind of document physicians may wish to use.

MSMS legal counsel cautions that no assurance of legal validity can be given to this document.

GENESEE COUNTY MEDICAL SOCIETY

806 Tuuri Place
Flint, Michigan 48503
Telephone 238-3781

IT IS RECOMMENDED THAT YOU
CONTACT YOUR ATTORNEY PRIOR
TO SIGNING.



Living Will Declaration

To My Family, Physician and Medical Facility:

I, _____, being of sound mind, voluntarily make known my desire that my dying shall not be artificially prolonged under the following circumstances:

If I should have an injury, disease or illness regarded by my physician as incurable and terminal, and if my physician determines that the application of life-supporting procedures would serve only to prolong artificially the dying process, I direct that such procedures be withheld and withdrawn and that I be permitted to die. I want treatment limited to those measures that will provide me with maximum comfort and freedom from pain. Should I become unable to participate in decisions with respect to my medical treatment, it is my intention that these decisions be honored by my family and physician(s) as a final expression of my legal right to refuse medical treatment, and I accept the consequences of this refusal.

Dated: _____, 199____, Signed: _____

Witness

Witness

DESIGNATION CLAUSE (optional*)

Should I become comatose, incompetent or otherwise mentally or physically incapable of communication, I authorize _____, presently residing in _____, to make treatment decisions on my behalf in accordance with my Living Will Declaration. I have discussed my wishes concerning terminal care with this person, and I trust his/her judgment on my behalf.

Dated: _____, 199____, Signed: _____

Witness

Witness

*If I have not designated a proxy as provided above, I understand that my Living Will Declaration shall nevertheless be given effect should the appropriate circumstances arise.

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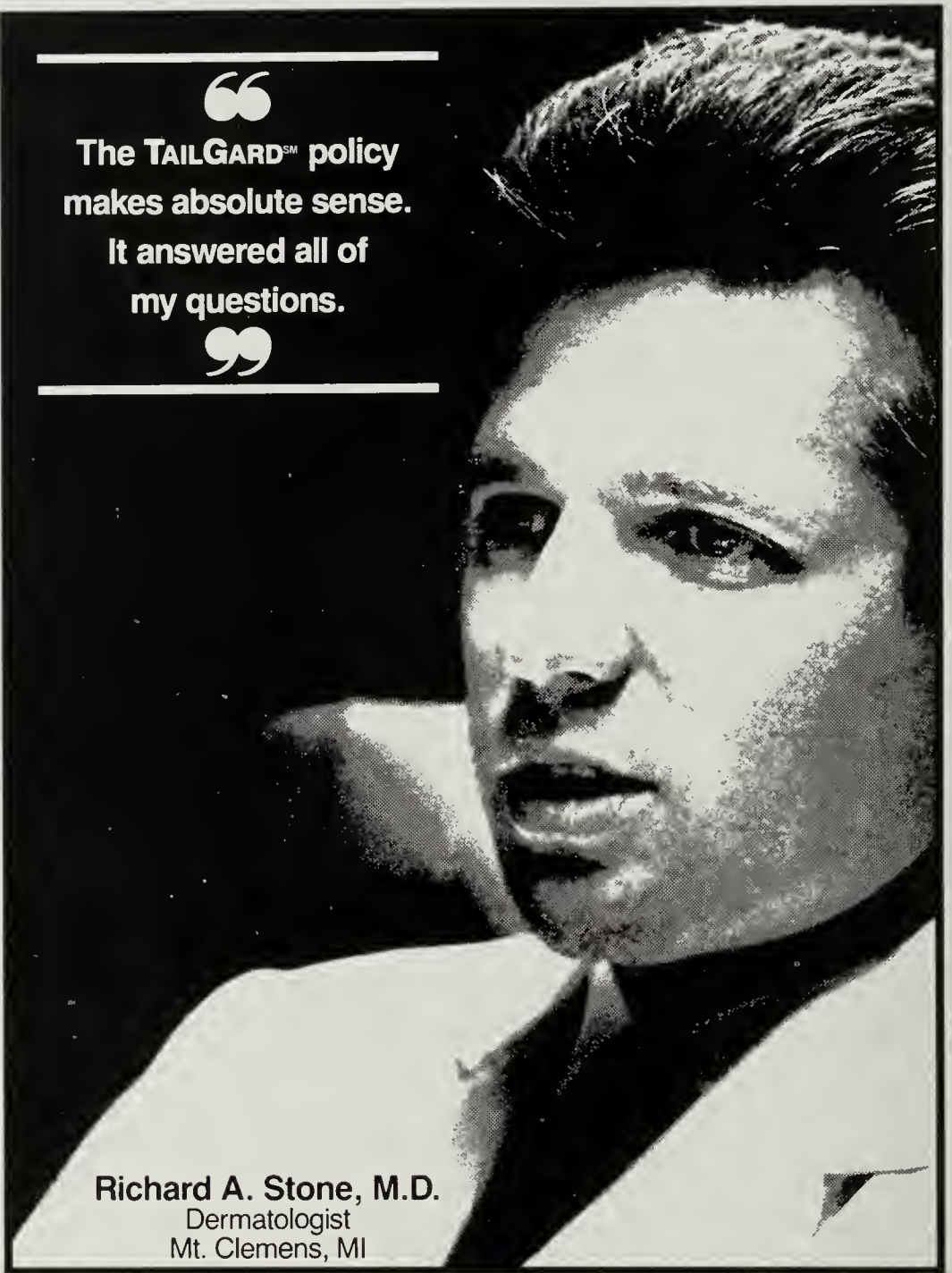
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”

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Data and Trends Affecting Michigan Physicians

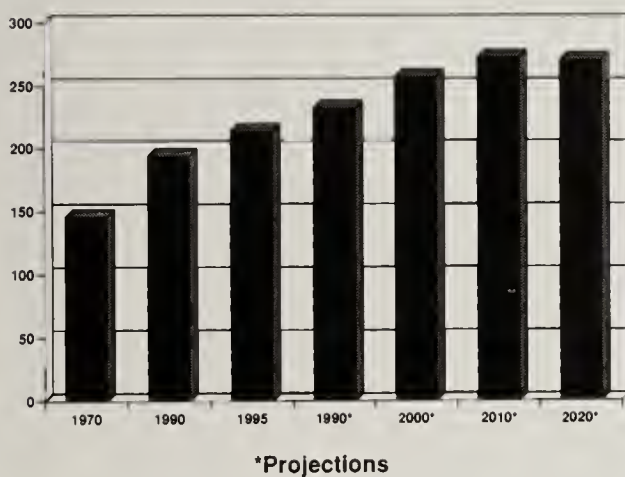
Issue 2

December, 1990

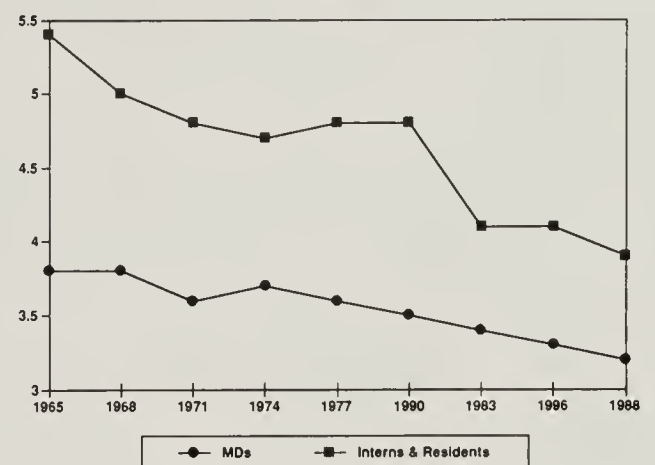
Physician Supply

Projections by the Office of Health and Medical Affairs indicate that the physician to population ratio in Michigan will increase until the year 2010, and then decrease slightly in 2020. In 1988, Michigan had 3.2% of the physician supply in the U.S., down from a high of 3.8% in 1965.

Active Physicians per 1000 Population
Michigan 1970-2020

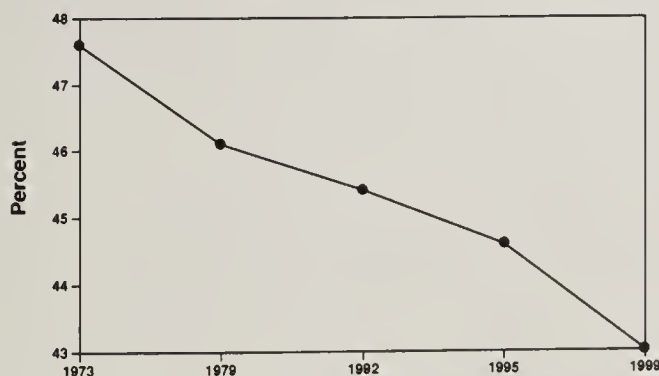


Michigan's Share of U.S. Physician Supply
1965-1988

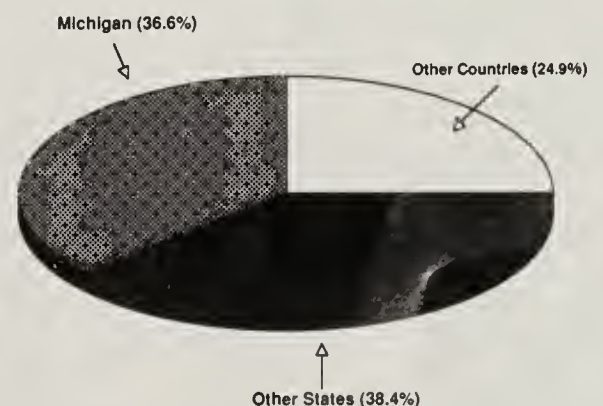


There has been a steady decrease in the percent of graduates from Michigan medical schools that remain in Michigan to practice medicine. In 1973, 48% of medical school graduates stayed in Michigan, while in 1989 that number had decreased to 43%. In 1985, a slightly larger proportion of the physicians in Michigan came from medical schools in other states (38.4%) than from Michigan medical schools (36.6%).

Michigan's Graduates Practicing in Michigan
Percent 1973-1989



Michigan Physician Supply by Location of Medical School
1985



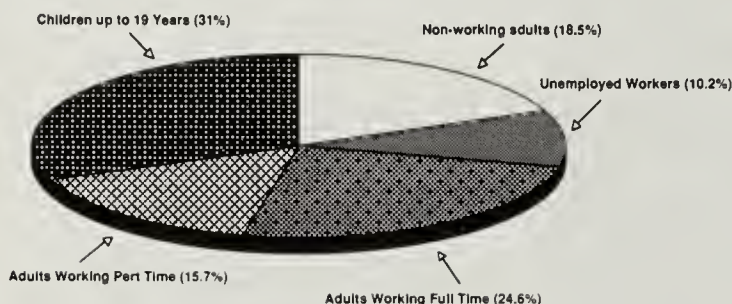
Source: Office of Health and Medical Affairs, Michigan Department of Management and Budget.
"Reference Data on Michigan's Physician Supply."

Michigan's Uninsured Population

Nearly one-third of Michigan citizens without health insurance in 1987 were children and over one-third were working adults. Central cities had the largest percent of uninsured at 13.5%, followed by rural areas at 11.5%.

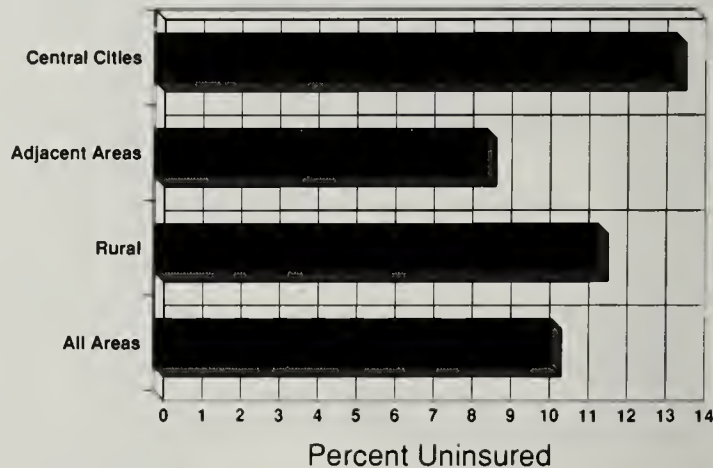
Persons Without Health Care Coverage

Michigan 1987



Percent Uninsured by Location

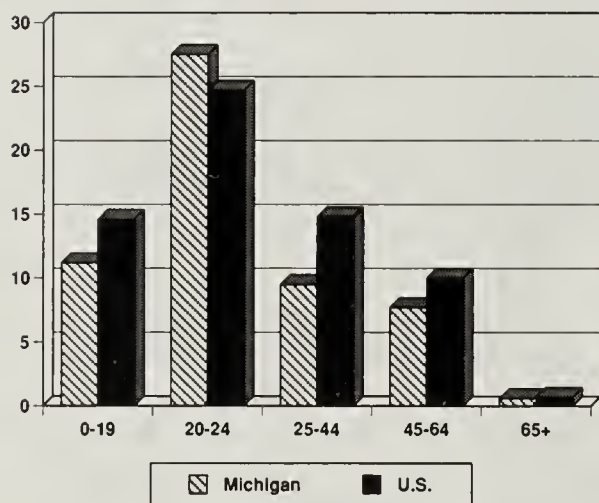
Michigan 1987



Twenty-eight percent of people age 20 to 24 were uninsured in Michigan in 1987. This age group has the largest proportion of uninsured of any age group in both Michigan and the U.S. The uninsurance rate varies by race also, with Blacks having the highest rate at 15%.

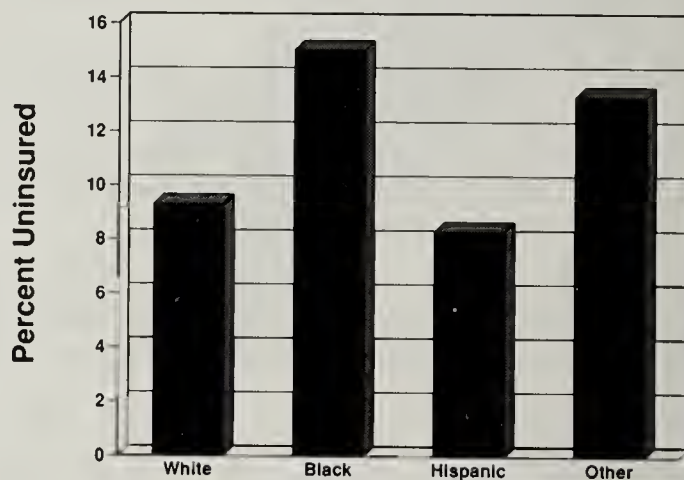
Uninsured Rate by Age

Michigan and the U.S. 1987



Uninsured Rate by Race

Michigan 1987



Source: Michigan League for Human Services. "The Uninsured Problem in Michigan." March 1989.

*Medical
Inquirer*

Data and Trends Affecting Michigan Physicians



A publication of the Michigan State Medical Society Department of Medical Economics and Health Care Delivery

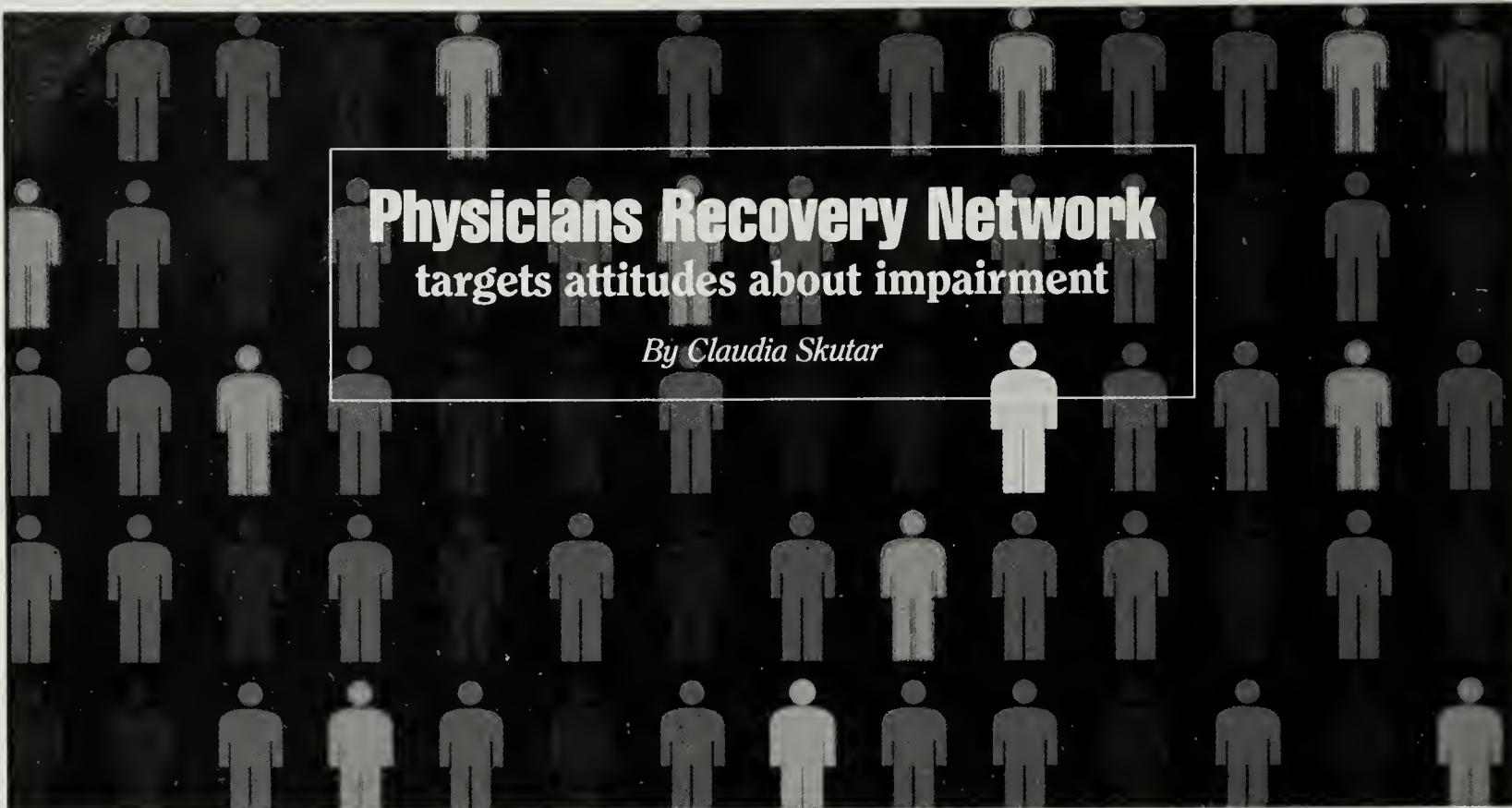
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Physicians Recovery Network targets attitudes about impairment

By Claudia Skutar

It is no coincidence that the name of the MSMS-sponsored organization which provides help to impaired physicians was changed from the Michigan Program to Assist the Impaired Physician to the Physicians Recovery Network (PRN).

The change was made to emphasize the group's focus on recovery rather than impairment, according to PRN Medical Director Gerald A. Vander Voord, MD. The name change occurred not long after Doctor Vander Voord was appointed to his post in 1987.

"The term 'impaired' is a pejorative term," Doctor Vander Voord explains. "Until we believe we can recover, we can't."

This philosophy has been the cornerstone on which PRN has built its help to impaired physicians. Until recent years, the prevailing attitude in many states toward treatment of impairment was a punitive one, although that is changing, says Doctor Vander Voord. People are now beginning to view impairment from alcoholism, drug addiction, or mental illness as a treatable medical disease rather than a moral issue. This change in attitude seems to garner positive results, he contends.

"By applying medical principles to this disease, we have had excellent results," he points out. "Those who believe that this is a disease and recognize the therapeutic process are the ones who recover. Those who believe that this is a willful misconduct...do not recover."

"We know that we're getting more peo-

ple into treatment and that we're monitoring them better," he added.

History of PRN

PRN's history as a physician-aid resource began in 1973 when the MSMS Board of Directors appointed an ad hoc committee to explore intervention for impaired physicians. The Board approved a policy statement in 1974, and appointed the MSMS Committee to Assist the Impaired Physician. The committee was charged with establishing an operating philosophy and structure, as well with casefinding and intervention.

During the late 1970s, as the issue of physician impairment began to receive more attention in the medical community, some county societies set up their own physician impairment committees. New operating guidelines for the MSMS program were developed in 1980, and the MSMS Board of Directors appointed then-MSMS President John R. Ylvisaker, MD, as the first chairman of the newly-named MSMS Program to Assist the Impaired Physician. A formal steering committee, composed of seven subcommittees, was appointed to oversee the new group's activities. The work of the committee was handled on a volunteer basis. It was the next committee chairman Carl A. Gagliardi, MD, who realized development of a formal program was necessary and set about developing that structure.

"Doctor Gagliardi recognized it was necessary to develop a program so that we

could keep track of doctors without duplicating our efforts," Doctor Vander Voord explains.

Doctor Gagliardi also advocated for appointment of a full-time target person to head the program, according to Doctor Vander Voord.

"I use the term target as somebody that can be called, somebody that can coordinate, somebody that can be responsible for doing as much as possible," he explains.

In 1985, the MSMS House of Delegates passed a resolution to hire a full-time physician as medical director to oversee the program, and, after a two-year search, Doctor Vander Voord was hired. In 1988, the program was renamed the Physicians Recovery Network to reflect a more positive attitude toward physician impairment. The committee retained the title MSMS Steering Committee on Program to Assist Impaired Physicians to distinguish it from the PRN program.

Doctor Vander Voord works to further PRN's goals, including educating people about impairment and how it can affect physicians. His activities include statewide speaking engagements on physician impairment and recovery, case identification, and case intervention. Case identification is one of the harder aspects of the job, Doctor Vander Voord says.

"Just because a person drinks doesn't make him an alcoholic," he explains. "Just because he uses drugs doesn't make him an addict. We're talking about the chronic, repetitive ingestion of a harmful chemi-

cal in such a way that it interferes with their life. Once we can recognize that it's interfering, then we've essentially got a case."

How it works

When an impaired physician is identified, there are a number of steps taken to help that physician.

"Intervention, as I view it and talk about it in our program, really has several layers," explains Doctor Vander Voord. "When a call comes in to the program, we approach the individual."

PRN talks with the individual in this first step to investigate and assess the situation.

The second step is an informal intervention in which the physician is approached and urged to discuss the problem. If the physician has difficulty accepting that he has a problem, a more formal intervention is done which involves coworkers, family, and friends gently pointing out that the physician has a problem for which help is needed.

A majority of the cases PRN handles are resolved within the first two or three steps. Only in a very small number of cases does PRN use a stronger approach

for physicians who may continue denying their impairment.

A more confrontational approach is used at this point, according to Doctor Vander Voord. This is when a physician is directly confronted with the need for treatment.

The final recourse is coercion, and this comes usually only after a legal incident has occurred and the physician is mandated by a judge or law enforcement official to get treatment. To date, PRN has not had to use this method of helping a physician to obtain treatment for impairment.

PRN tries to reach physicians before serious problems develop, providing access to counseling and treatment which allows them to recover and continue on with their lives.

"Most often if we can approach someone before he has trouble, we have better success in helping him," says Doctor Vander Voord.

Treatment for impairment is immediate and mainly residential, according to Doctor Vander Voord. Intensive outpatient treatment can be successful in some cases, but inpatient treatment tends to be the more effective method.

"We try to get the physician chemical-

free for 28 days to get a better picture of what the person needs," he explains.

One of the most important facets of treatment is to help the impaired physician understand in his own mind that a problem exists, but that it can be successfully treated, he notes.

High recovery rate

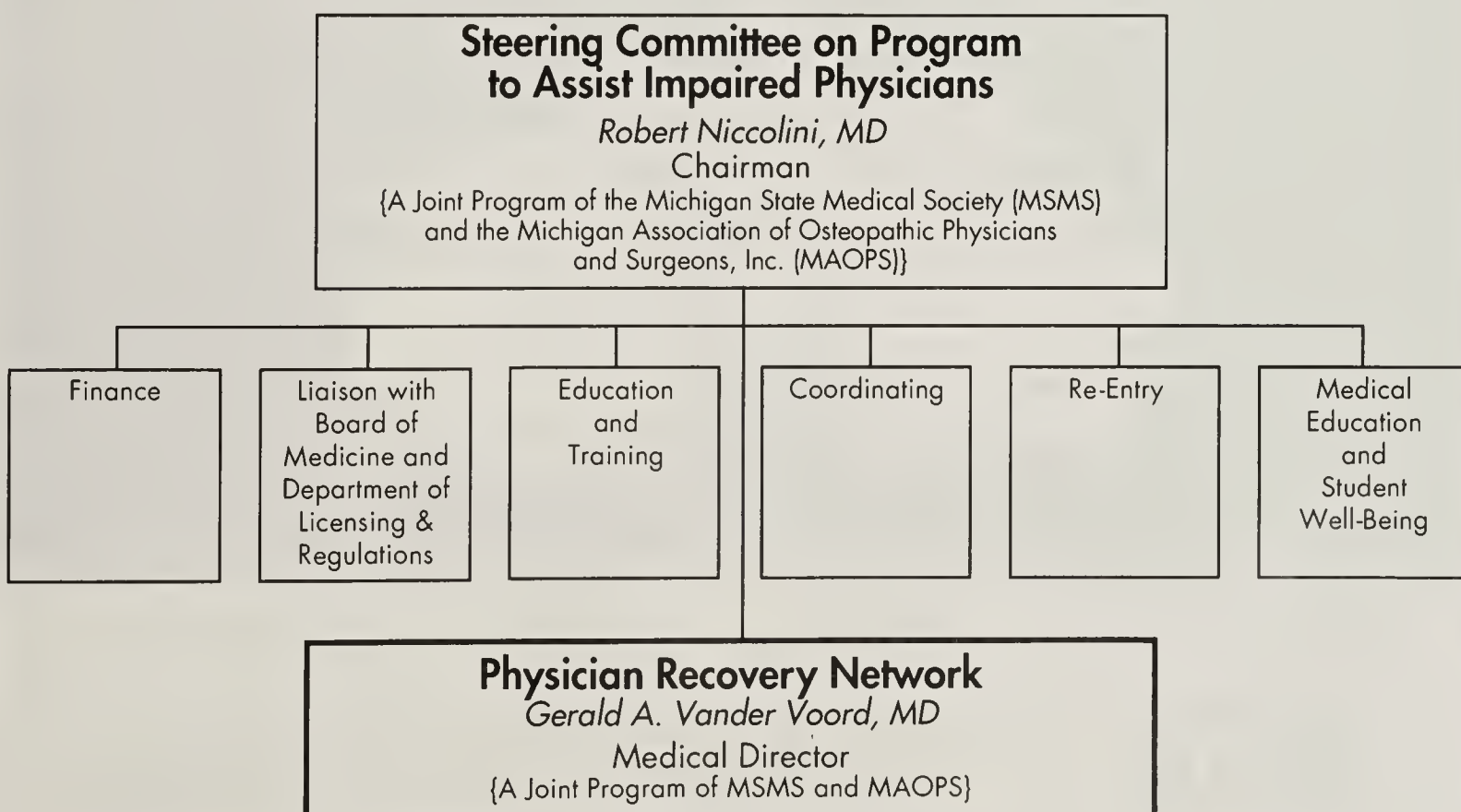
Treatment centers, which follow a patient two years after treatment, have a 95 percent recovery rate, according to Doctor Vander Voord. "They've improved treatment and are now treating a broader range of chemical dependency," he says.

National statistics indicate that 10-12 percent of the population as a whole abuses alcohol and other chemicals, according to Doctor Vander Voord. Because physicians are people, too, he estimates about the same percentage of physicians are substance abusers, with about one percent receiving treatment.

Physicians are not more susceptible to impairment through substance abuse than the general public, Doctor Vander Voord notes. The difference between physicians and the general population is that

Continued on next page

Physicians Recovery Network (PRN) Organizational Chart



Continued from previous page

physicians have access to a wider range of chemicals, sedatives and narcotics.

After treatment is completed, PRN oversees monitoring of the physician's condition to collect evidence of recovery. Monitoring by PRN may continue for up to three years. The network accumulates the information and then acts as advocate for the physician in proving, if necessary, to authorities that the physician is recovering.

"We follow the individual as best we can," Doctor Vander Voord says. "We're trying to help that physician develop a clean record, because once it's soiled, it doesn't just go away."

PRN has helped 325 impaired physicians towards recovery since 1989. Of that number, 119 cases are currently active, with those physicians receiving treatment or in recovery. The number of cases reported to PRN is related to the time available to make people aware of the network as a resource, according to Doctor Vander Voord.

Funding limited

The network currently relies on limited

funding from several sources, including joint program sponsors MSMS and the Michigan Association of Osteopathic Physicians and Surgeons, Inc. (MAOPS). Two Michigan physician insurance groups, Michigan Physicians Mutual Liability Company (MPMLC) and Physicians Insurance Company of Michigan (PICOM), currently provide grants to the program. PRN also is exploring additional sources of funding, including foundation grants. This year Blue Cross Blue Shield of Michigan (BCBSM) awarded reimbursement to MSMS of up to \$5,000 toward the cost of writing a grant proposal to solicit further funds under BCBSM's Research Support Venture for Physicians (R.S.V.P.) program.

While adequate funding of PRN is necessary for the program's continued operation and success, the state is considering creation and funding of its own health professionals impairment program in a package of bills that would reform Michigan's physician and licensure discipline system.

House Bill 4712, introduced by Rep. David Gubow (D-Huntington Woods) would create a Health Professional Recovery Committee to oversee nondisciplinary

responses to substance abuse, drug dependency and mental illness. The bill, still pending in the Legislature, is tie-barred to two other bills in the package, House Bills 5912 and 5913, which also are still under consideration. Passage of these bills would amend the State License Fee Act to establish the Health Professions Regulatory Fund in the state treasury and would permit the Department of Licensing and Regulation to increase health professionals' license fees to pay for the program.

In the meantime, while the bills are being debated in the Legislature, PRN continues to work to help impaired physicians toward recovery.

"Those that we can get to, convince they've got a disease, and then follow treatment, get better," he says. "We direct people into treatment."

Doctor Vander Voord compares recovery to climbing Mt. Everest. Until somebody climbed the mountain, he says, nobody believed it could be done.

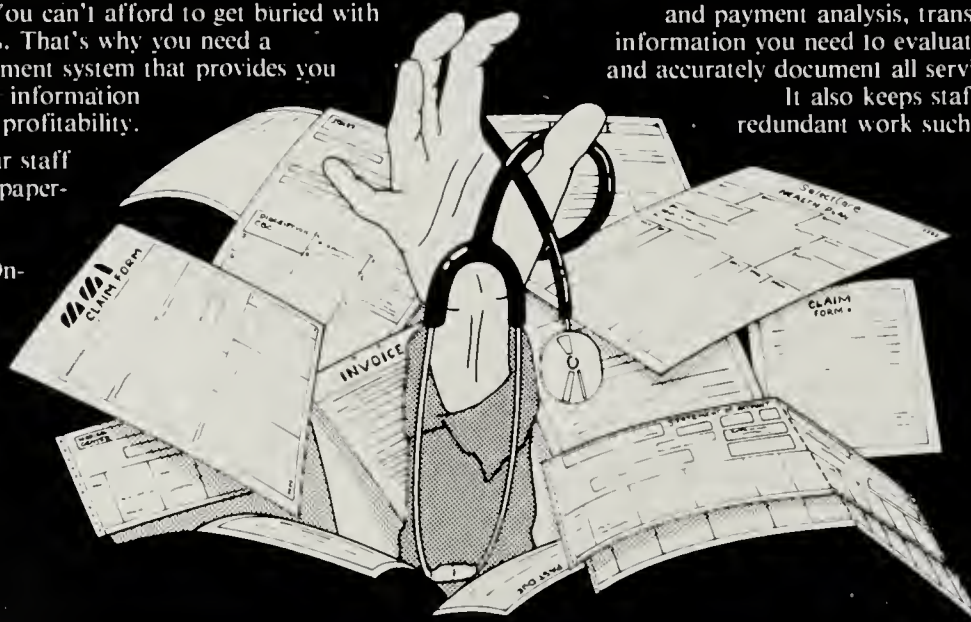
"[Recovery] is a belief system and people...are beginning to believe that recovery is possible," he says. ■

Claudia Skutar is communications specialist for MSMS.

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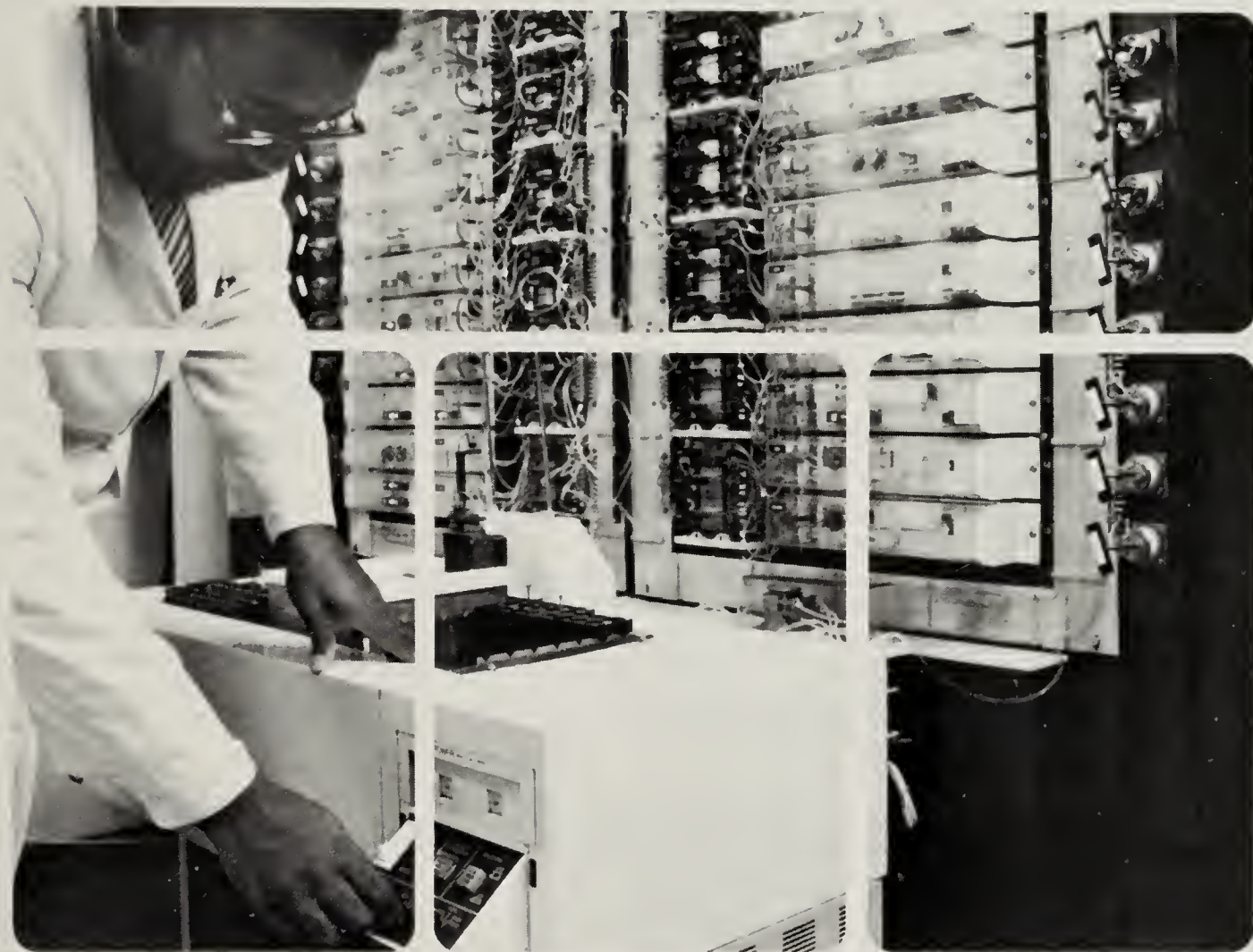


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DSS

expands project to assist low-income persons with AIDS

By Scott D. Merwin

The Department of Social Services (DSS) recently expanded an innovative pilot project to assist low-income persons with AIDS to continue their private insurance coverage. The program became available statewide on November 1, 1990.

The program, called the Insurance Assistance Program for People with AIDS, pays insurance premiums for low-income people who, because of AIDS related disease, are unable to continue working and thus may lose their health insurance.

The project began October 1, 1989, in Wayne, Oakland, and Macomb counties and has assisted about 60 people since then. A DSS cost analysis shows the program saves the state about nine dollars in Medicaid costs for every one dollar spent on insurance premiums. DSS expects enrollment to increase to over 100 people in the next year with statewide expansion.

Background

Perhaps the greatest weakness in the US health care system is that over 30 million people lack any health insurance. One of the most perverse dynamics in our system is that the very people who need health insurance the most — the sick and dying — are the people at greatest risk for losing private health insurance. This is particularly true for persons with AIDS. In Michigan, nearly 50 percent of the persons with full blown AIDS become Medicaid eligible. The need to maintain private insurance where possible is thus particularly acute for persons with AIDS.

The concept of the Insurance Assistance Program is simple. A federal law included in the Consolidated Omnibus Budget Reconciliation Act (COBRA) enacted in 1986 allows persons working in companies with at least 20 employees to continue health insurance at their own expense. Persons who are disabled when they leave employment may continue insurance for up to 29 months; others may continue insurance for up to 18 months. But when people are too sick to work, they frequently lack the resources to pay their insurance premiums. Eventually, many of these people, having lost their insurance, qualify for Medicaid.

The Insurance Assistance Program will

assist any qualified person who has health insurance to continue it. Many persons with health insurance are not covered by COBRA, for example, persons working at small companies or persons who purchase insurance privately. These persons can also qualify for the program.

To qualify for the program a person with HIV infection must have:

- Income of less than about \$1,000 per month;
- Cash assets of less than \$10,000; and
- A physician statement that the person is too sick, or likely will be within three months, to continue working.

Criticisms of program

Critics of the program fall into two camps — those who believe the program is too limited, and those who believe the very existence of the program is too expansive.

Those who believe it is too limited argue that eligibility should not be confined to persons with HIV infection. I recently had a conversation with a woman whose husband has cancer. She argued desperately that the state should pay their insurance premium. She stated the family had medical bills of \$50,000 last year that were covered by private insurance. But with the husband not working they could no longer afford the \$400 per month premium. She could not understand why the state would rather impoverish the family and then pay the medical bills through Medicaid than pay the insurance premium. She was particularly bitter because if her husband had AIDS his premium would have been paid.

Others argue the very existence of the program is too expansive because it only serves to shift costs from the state to employers and private insurance. Ultimately, higher costs to employers and private insurance companies must be passed on to consumers through higher prices or higher insurance rates.

The reason the program was started and the reason it is limited to AIDS are related. In Michigan about ten percent of the population is Medicaid eligible, yet nearly 50 percent of the persons with AIDS are Medicaid eligible. These figures are reflective of the experience across the

country in which the financial burden of the AIDS epidemic is weighted heavily onto taxpayer-funded programs. This is why the Insurance Assistance Program was targeted only at persons with AIDS.

Physician involvement

One of the keys to the program is making sure that people who are eligible for the program apply before they lose coverage. Physicians can be helpful by making sure their patients with HIV infection are aware of this special program. DSS would be happy to provide a supply of applications to physicians who would like them available in their office.

Applications may be requested from the Insurance Assistance Program by calling (313) 256-1377. Applications are also available at local Department of Social Services offices. Completed applications and written inquiries should be directed to: Insurance Assistance Program, Michigan Plaza Building, 11th Floor, Executive Suite, 1200 Sixth Street, Detroit, Michigan 48226.

For further information about the program please contact: Denise Johnson, Program Coordinator, (313) 256-1377 or Scott Merwin, Program Manager (517) 335-5121.

A friendly reminder

DSS administers a special drug coverage to help low and middle income persons with AIDS pay for drugs. It covers Zidovudine (AZT) and all FDA approved drugs for the treatment of infections and tumors associated with HIV infection. Persons may qualify if they do not have insurance that fully covers their drugs, and are not eligible for Medicaid, General Assistance Medical, or CountyCare. Details of the program are described in Medicaid Bulletin 5310.1-90-08. To initiate eligibility, a physician may telephone (517) 335-5181, or write the Medical Consultants, Bureau of Health Services Review, Medical Services Administration, P. O. Box 30037, Lansing, Michigan 48909. ■

The author is program specialist for the Bureau of Program Policy, Medical Services Administration, Michigan Department of Social Services.

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Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

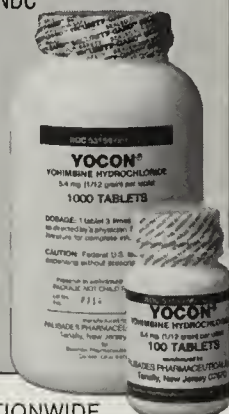
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Patients' well-being depends upon a collaborative effort between physician and patient

AMA identifies six patients' rights

Editor's note: Set forth below is the report of the AMA Council on Ethical and Judicial Affairs entitled "Fundamental Elements of the Patient-Physician Relationship."

From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance. Physicians can best contribute to this alliance by serving as their patients' advocate and by fostering these rights:

1) The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.

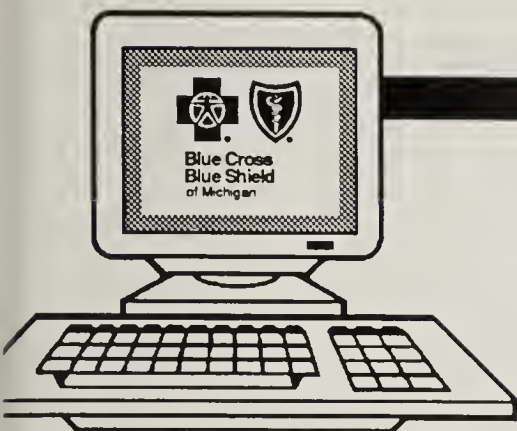
2) The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.

3) The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.

4) The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

5) The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements for care.

6) The patient should have the right to essential health care, and physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care. ■



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Adequate documentation

vital to peer review process

By Donald H. Kuiper, MD

The following article was recently presented to members of the MSMS Liaison Committee with Michigan Peer Review Organization (MPRO).

There is no question that we physicians must justify our actions in the clinical arena in a more detailed form than ever before. Third-party payors, the government, HMOs, PPOs, and the Joint Commission are all requiring complete and careful documentation of the reasons why we do the things we do to our patients. It is no longer good enough for us to say, "I am recommending this or that course of action because it is in the best interest of the patient." In today's environment our database used by us to make clinical recommendations must be clearly and completely documented in the medi-

cal record. Failure to do adequate documentation may result in the breakdown of the peer review process, denial of payment to both the physician and the hospital, and more onerous, the rendering of a quality citation by an agency such as Michigan Peer Review Organization (MPRO).

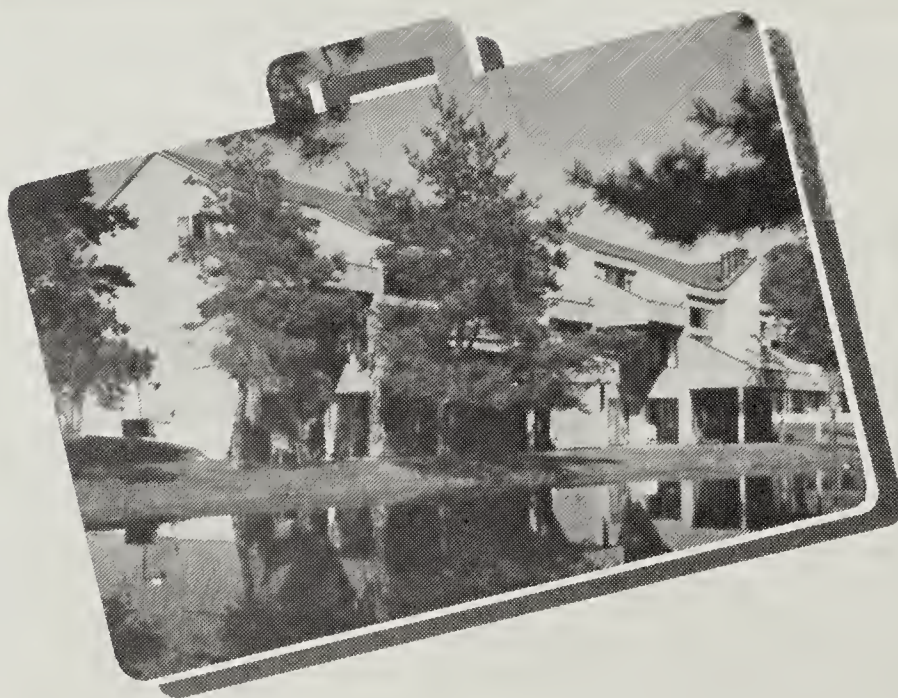
The Michigan State Medical Society Liaison Committee with MPRO meets regularly and reviews physician interactions with MPRO. The Committee believes that an article illustrating an example of the need to document would be useful to the membership. What follows is an actual case report recently cared for by the author and I hope it will illustrate the importance of documentation in arriving at clinical decisions.

A 17-year old male presented with a

history of fever, fatigue, nausea and vomiting. Initial physical examination revealed large tender submandibular lymph nodes. He had been seen in the hospital emergency department on two previous occasions, where he received intravenous fluids and was found to have a positive test for infectious mononucleosis.

Forty-eight hours following the last emergency department visit the patient's mother called me while I was on call for the primary care physician. It was reported that the patient was unable to retain any oral food or fluid. He was extremely weak and was unable to get out of bed because of vertigo. He continued to experience fever up to 102 degrees on an intermittent basis. His urine was reported to have a dark color and very strong odor. Because he was unable to retain any food

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or fluid without vomiting and had weakness and dizziness, admission to the hospital was believed to be necessary.

On admission to the hospital, the patient was flushed and had a tint of scleral icterus. His temperature was 102 degrees orally. His pulse was 116 and regular. His blood pressure was 120/72 supine and fell to 95/68 in the seated position. His mucus membranes were dry and skin tissue turgor was decreased. He had several tender enlarged cervical and submental lymph nodes. The spleen and liver were not enlarged. Pertinent laboratory studies revealed a urine specific gravity of 1.005, the BUN and serum creatinine were normal.

I was surprised at the low urine specific gravity in a patient that was clinically dehydrated. Careful additional questioning of the patient's mother and the patient revealed that the patient had received two liters of intravenous fluids in route to the hospital in the ambulance. Urine passed in the ambulance had been discarded. Upon arrival to the hospital, IV fluids were continued at a high rate and voided urine again was discarded on two occasions before a urine was finally sent to the laboratory for urinalysis.

After 36 hours in the hospital, the patient's fever decreased and he was able to eat and drink normally. He was then discharged to the outpatient status.

Discussion

I have documented the pre-admission events in the patient's hospital chart. If this medical record had been reviewed by a peer retrospectively, nothing in the record reflecting in hospital care would have explained the normal urine specific gravity on this patient. However, after going back and doing further questioning of the patient and his mother, it becomes obvious why the patient's urine specific gravity was normal when it finally was measured during his hospitalization. A criterion for intensity of service on a dehydrated patient is a high urine specific gravity. With a normal urine specific gravity in the patient's medical record, it would be highly likely that the patient's admission might have been denied by the external peer review organization. This pitfall could have been clearly avoided if careful questioning had taken place, as well as an adequate search for an explanation, followed by documentation in the record. ■

Doctor Kuiper is vice president for medical affairs, St. Lawrence Hospital, Lansing.



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Your back office can cost you precious time and money

By George S. Conomikes



A prominent physician once told me that he approached his back office as he approached his bedroom — reluctantly, often impulsively, and usually in the dark. One of the least examined areas of the medical practice is the activities in the back office.

Our studies of the activities, motions, patient flow and communications patterns of many practices have shown us significant time losses, needlessly spent energy and direct effects on productivity.

The following suggestions assume that the physician wishes to maintain a satisfactory flow of patient contacts, with as little “down” time as possible. Also, we are interested in conserving the physician’s energy-effort expenditure (and that of his back office personnel).

Don’t have patients waiting in back office areas. They are seeing too much. They may expect to be able to converse with physicians or nurses. They don’t like being “shuttled” from reception room to back office waiting area to examination room. They get in the way.

Have examination rooms in a smooth flow. Don’t have your consulting room in the middle of two, three or four examination rooms. You will overuse the consulting room or you will waste steps walking past the consulting room, which should be at one end or another of your examination rooms layout.

Try to make the examination room work. Most physicians are finding that their entire patient contact can take place in the examination room.

Don’t overuse the consulting room. Patients don’t expect it; it slows you down and may involve you in redundant conversation.

The biggest time-wasting flow is meeting the patient in the consulting room; then examining in the examination room; followed by a “results” session in the consulting room.

You may think the patient is getting

more personal service, but in fact the patient is being made to wait for you three times rather than once.

Don’t be interrupted. One of our studies of a dermatologist’s practice indicated, on the average, that each patient-physician contact was interrupted three to four times by phone calls. It’s rude to the patient, and it slows you down. Most calls can be held for a call-back.

Try to make the examination room as small as possible. Save steps; be able to reach most things you require for examining the patient. Be able to have more examination rooms rather than a few large ones. Have reading matter on hand for the patients so their waiting time doesn’t drag in the examination room.

Observe the 40 inch rule. Most things used most of the time in the examination room should be within 40 inches (your reach capability) of where you are usually located when working with the patient. This means lights and light switches; instruments; dressings; gloves; depressors; towels; medications; and maybe the wash basin. Don’t walk when you can reach.

Keep cabinets within reach. Wall cabinets that hold frequently used supplies should not necessarily be located flush to the ceiling. Sometimes they should be lowered for easier access by you and your aides.

Have a minimum of three examination rooms. If you leave Room 1, and the patient in Room 2 is a “quickie,” the patient in Room 1 may still be dressing or grooming. You are stopped if you don’t have a third examination room with a readied patient.

Have a “work station.” Rather than a traditional nurse’s station, there could be a working surface within the flow of the back office, out in the open with two phones, one for the doctor and one for the nurse. Nursing stations that are behind walls mean that you can’t easily see the

physician(s).

A good “work station” can be used by the doctor, as well as the nurse, for most call-backs: calls from other physicians; writing of quick notes; hospital contacts; quick conferences with nurses and/or colleagues; and dictation.

Set up a communications system. It is good to have some sort of signaling device (pull-out flags, discs, lights, etc.) that indicates who’s in the examination room — patient, doctor, or nurse. Also, some sort of system, such as a buzzer, to call a nurse or technician, is generally helpful in reducing physician down-time.

Don’t “lose” the nurse. Many doctors complain that their nurse is not there “when I need her.” Usually, this is related to the fact that he really has not properly integrated her into his work pattern and preferences. Sometimes it is due to her being unnecessarily interrupted to handle tasks (patient phone calls, hospitals, pharmacies, labs, etc.) that could be deferred for a few minutes.

Arrange for a break-time. It may be helpful for some practitioners to consider improving their flows by taking a break-time of about 15-20 minutes every 90 minutes. This time would be utilized by the physician and his nurse to do their call-backs, chart review and communication with others in the practice.

In this way patient contact time could be maximized. Less interruption would result, and a helpful change of pace from “hands-on” medicine is built into the busy practice day. ■

George Conomikes is considered a leading authority on practice management. He is editor and publisher of Conomikes Reports, and the author of a book entitled Practice Management Techniques. The above article was provided compliments of Physician Service Group, Inc., an MSMS subsidiary.

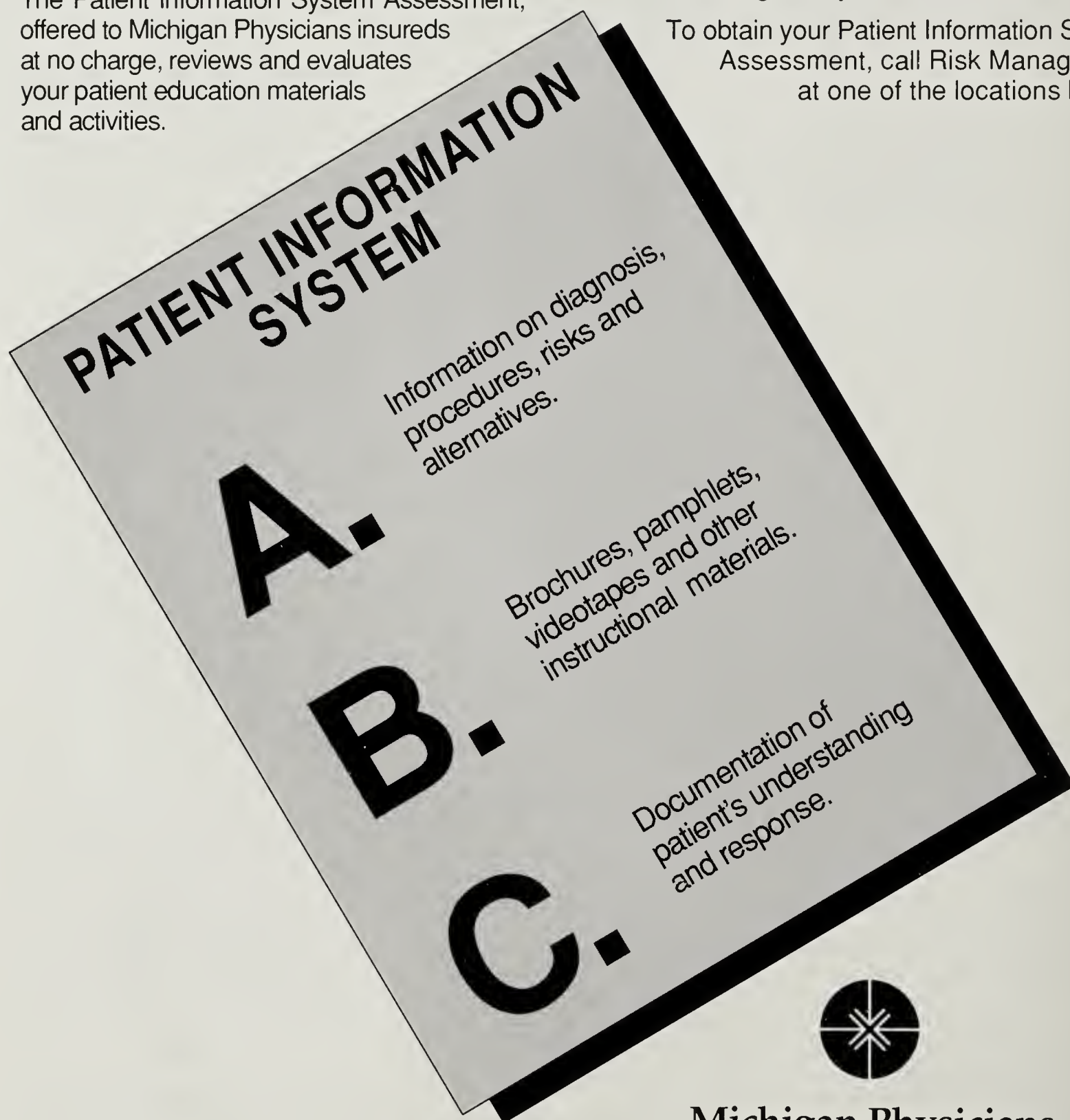
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Robert M. Leitch, MD

May 20, 1917 –
September 14, 1990

**He was a rare and
special human being**

By Thomas R. Berglund, MD

To every person who knew Bob Leitch, he was a caring, humane, sincere and humble man...but with a great sense of humor.

To me, he was even more.

My father died when I was eight years old. Bob was the closest thing to a father I ever had. He also was my role model, although I understood I could never reach his level.

With his passing September 14, the medical community, and all those with whom he came in contact, lost a true leader and valued friend.

Remembering Bob Leitch is easy. He is unforgettable, with an array of energy, intellect, analytical ability, medical skill, musical and literary talent...and, of course, unmatched humor and unparalleled story-telling ability.

My memories of Bob are, and will remain, endless.

Bob had an enduring commitment to his profession, his patients, his family, friends and two organizations he admired and loved...the Michigan State Medical Society (MSMS) and Michigan Physicians Mutual Liability Company (MPMLC).

He was an active and avid force in the medical community and served as MSMS president, as well as secretary.

As one of the leaders of MSMS, Bob

was a key figure in creating MPMLC during the professional liability insurance crisis of the mid-1970s. He was a founder and board member of MPMLC from the company's inception in 1976 until May 11, 1988, when health problems precipitated his resignation.

He had been MPMLC president and chairman of the board from 1980 to November, 1987.

Bob had an uncanny ability to dig through complexities and focus on key needs and issues. He could be strikingly insightful, yet surprisingly humorous.

I really believe Bob Leitch had a story or joke to fit any and every occasion. And I don't ever recall seeing or hearing him stop at just one. Bob was a high-roller of story-telling and when on a roll it seemed his resources were inexhaustible.

Once at an MSMS summer board meeting, our good friend and colleague Ernie Griffin, MD, brought a "hot shot" jokester from the Flint area to *presumably* overshadow Bob in a sort of contest.

They "dueled" for hours until Ernie's ringer ran out of gas. But Bob was still going strong.

Most of us will always remember Bob as a robust and energetic personality that could tackle tough issues or entertain audiences.

Bob had immense impact in addressing liability needs and when he resigned from the MPMLC board, board members bestowed on him the title "president emeritus."

When Bob's health problems began slowing him down, I was asked to step in as acting president and chairman of MPMLC's board. Bob had always been helpful and inspirational to me ever since I joined the MPMLC board in 1985.

I believe I speak for all those who knew and worked with Bob in saying he was a rare and special human being who consistently was admired, respected and loved.

Bob Leitch was a father-figure, role model and mentor; his impact will never die.

His loss is as exceptional as his life. ■

Doctor Berglund, a Portage family physician, is president of and chairman of the board of MPMLC and is a member of the MSMS Board of Directors.

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Frank D. Adams, MD — AN
3454 Oakleaf
Troy 48084

Dirk H. Alander, MD — ORS
1801 Brenton, SE
Grand Rapids 49503

Andrew W. Asimos, MD — EM
1012 Henrietta St.
Birmingham 48009

Scott Berman, MD — DR
731 Kenmoor, SE
Grand Rapids 49506

Robin A. Blumer, MD — OBG
28625 Northwestern Hwy. #100
Southfield 48034

Jack L. Clark, MD — OTO
2799 W. Grand Blvd.
Detroit 48202

Donald P. Condit, MD — ORS/HS
1900 Wealthy St., SE #290
Grand Rapids 49506

Robert H. Connors, MD — PDS/GS
21 Michigan, NE #710
Grand Rapids 49503

Brian W. Cook, MD — EM
740 N. Macomb
Monroe 48161

Cynthia L. Cookingham, MD — PD/AI
7210 Ortonville Rd. #200
Clarkston 48016

Douglas O. Corey, MD — P
951 E. Lafayette
Detroit 48207

Robert I. Cutcher, MD — FP
2433 Black River St.
Deckerville 48427

Waad Dakkak, MD — IM
2011 Middlebelt
Garden City 48135

Cheryl Davison, MD — ON

100 Michigan, NE
Grand Rapids 49503

Jasveen K. Dhadli, MD — P
4201 St. Antoine
Detroit 48201

Martin Farber, MD — OBG/END
18101 Oakwood Blvd.
P. O. Box 2500
Dearborn 48123

Kumudinie C. Fonseka, MD — IM
19603 E. Eight Mile Rd.
St. Clair Shores 48080

Philip Fox, MD — P
300 68th. St., SE
Grand Rapids 49501

Anne T. Gillis, MD — CHP
30152 W. Warren #99N
Westland 48185

David A. Ginnebaugh, MD — FP
4095 Blue River Dr.
St. Clair 48079

David M. Grossman, MD — PTH
1501 Avondale
Ann Arbor 48103

Brian V. Guz, MD — U
22151 Moross Rd. #320
Detroit 48236

Glen H. Hastings, MD — GS
23530 Cherry Hill
Dearborn 48124

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420 W. Magnetic
Marquette 49855

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18101 Manorwood Circle
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Detroit 48201

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611 W. Belle Ave.
P. O. Box 248
St. Charles 48655

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2408 Essex Rd.
Ann Arbor 48108

Thomas J. Jennings, MD — OPH
820 Lester Ave.
St. Joseph 49085

Gregory W. Johnson, MD — GS/FP
245 Cherry St. #101
Grand Rapids 49503

Richard N. Joyrich, MD — R
1900 Wealthy St., SE #250
Grand Rapids 49506

Arlene V. Kevonian, MD — CHP
5524 Stanhope
West Bloomfield 48322

Fuad Khaznehkathi, MD — CD/IM
2515 Woodward #260
Bloomfield Hills 48013

Pamela R. Knysz, MD — FP
2660 44th. St., SW
Wyoming 49509

Kenneth A. Kron, MD — P
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Detroit 48201

Alma M. Latham, MD — FP
5498 109th. Ave.
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Southfield 48075

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1477 S. Sheldon Rd. #4
Plymouth 48170

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26543 Berg Rd. #360
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2180 Ridgemont
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David M. Moses, MD — NPM
7388 Deep Run
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5719 Middlesix
Dearborn 48126

Leonard J. Owsiany, MD — FP
440 Rowe Rd.
Milford 48042

Christine Parcells, MD — P
945 Lakepointe
Grosse Pte. Park 48230

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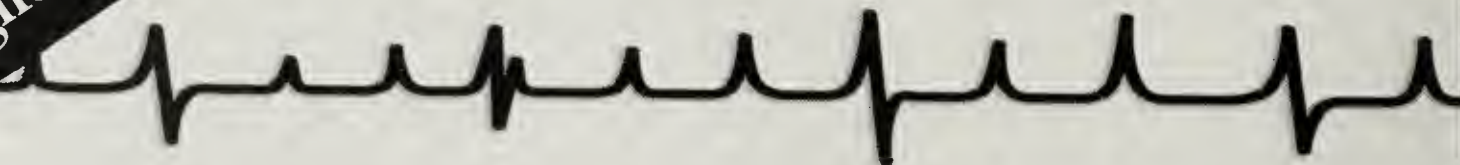
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Continued from previous page

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Robert L. Pintozzi, MD 820 Lester Ave. St. Joseph 49085	— IM/GE	Shiela Shelby, MD 17191 Ardmore Detroit 48235	— PM	Chad R. Williams, MD 731 Kenmoor, SE Grand Rapids 49546	— DR
James E. Puklin, MD 4717 St. Antoine Detroit 48201	— OPH	Theresa P. Stanton, MD 15770 Grandville Detroit 48223	— AN	David B. Wolf, MD 39595 W. 10 Mile Rd. #105 Novi 48050	— IM
Vijaya C. Ramesh, MD 29029 Foresthill Dr. Farmington Hills 48331	— IM	Michael G. Taylor, MD 1799 E. Grand Blvd. Detroit 48211	— IM	Danny E. Young, MD 1800 Traver Ann Arbor 48105	— AN
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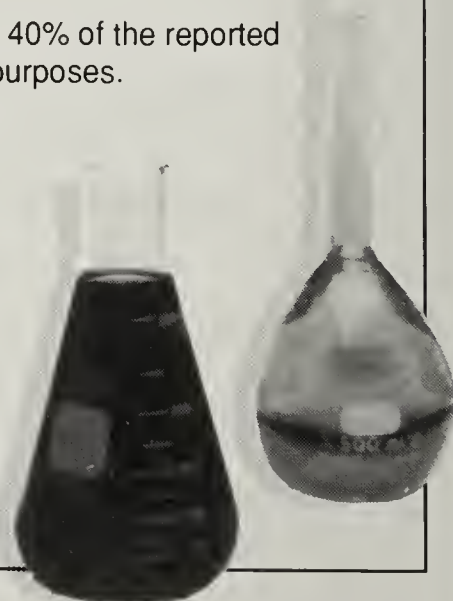
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Michigan Medicine

Statement of Ownership, Management & Circulation

Statement required by 39 U.S.C. 3685 showing the Ownership, Management & Circulation of Michigan Medicine, published monthly (12 issues) for November 28, 1990. Publication No. 00262293. Annual subscription price \$40.

1. Location of known office of Publication is PO Box 950, East Lansing, Michigan 48826-0950.
2. Location of the Headquarters or General Business Offices of the Publisher is PO Box 950, East Lansing, Michigan 48826-0950.
3. The names and addresses of the publisher, editor and managing editor are: Publisher, Michigan State Medical Society, PO Box 950, East Lansing, Michigan 48826-0950; Editor, Betty J. McNerney, PO Box 950, East Lansing, Michigan 48826-0950; Managing Editor, none.
4. The owner is: Michigan State Medical Society, PO Box 950, East Lansing, Michigan 48826-0950.
5. Known bondholders, mortgagees, and other security holders owning or holding one percent of total amount of bonds, mortgages or other securities are: None.
6. The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes has not changed during preceding 12 months.
7. Extent and nature of circulation:

	Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
A. Total No. Copies Printed	10,603	10,300
B. Paid and/or Requested Circulation		
1. Sales through dealers and carriers, street vendors and counter sales	-0-	-0-
2. Mail Subscriptions	9,647	9,328
C. Total Paid and/or Requested Circulation	9,647	9,328
D. Free Distribution by mail, carrier or other means, samples, complimentary, and other free copies	706	706
E. Total Distribution	10,353	10,034
F. Copies Not Distributed		
1. Office use, left-over, unaccounted, spoiled after printing	250	266
2. Returns from News Agents	-0-	-0-
G. Total	10,603	10,300

8. I certify that the statements made by me above are correct and complete.

(Signed) Betty J. McNerney, Editor

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

December

6, Update In Cardiovascular Disease 1990. **Location:** Eleanor N. Dana Center, Toledo, Ohio. **Sponsor:** Medical College of Ohio. **Contact:** Susan Hahn, Office of Continuing Medical Education, Medical College of Ohio, P. O. Box 10008, Toledo, OH 43699-0008, (419) 381-4237. **Approved for:** 6 hours Category I Credit.

6, Recent Advances in the Surgical and Non-Surgical Management of Complex Hepatobiliary and Pancreatic Disorders. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Surgery. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201,

University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 7 hours Category I Credit.

7, Basic Life Support For Health Professionals. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gwen Goldfarb, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 5 hours Category I Credit.

8, Advanced Cardiac Life Support Instructor Course. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gwen Goldfarb, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 7 hours Category I Credit.

14-15, Advanced Trauma Life Support. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, The Michigan Committee on Trauma, and The American College of Surgeons. **Contact:** Teresa Mitchell, Office of Continuing Medical Education, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 18 hours Category I Credit.

February

3-6, First Annual Mid-Winter Symposium. **Location:** Harbor Cove, Harbor Springs, Michigan. **Sponsors:** Michigan State University, Kalamazoo Center for Medical Studies. **Contact:** Charles L. Zeller, Jr., MD, 1535 Gull Road, Suite 230, Kalamazoo, MI 49001, (616) 383-7363. **Approved for:** 7 hours Category I Credit.

3-8, 15th Annual Midwinter Family Practice Update. **Location:** Boyne Highlands Inn, Harbor Springs, Michigan. **Sponsors:** University of Michigan Medical School and Michigan Academy of Family Physicians. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 22 hours Category I Credit.

11-15, Ninth International Postgraduate Course on Myocardial Infarction and Angina Pectoris. **Location:** Convention Center, Davos, Switzerland. **Sponsors:** University of Michigan Medical School and Hannover Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 28 hours Category I Credit.

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CATEGORY I COURSES

17-22, 16th Annual Seminar on Emergencies in Medicine. **Location:** Boyne Highlands Ski Lodge, Harbor Springs, Michigan. **Sponsor:** Detroit Receiving Hospital. **Contact:** Robert F. Wilson, MD, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit, MI 48201, (313) 745-3484. **Approved for:** 25 hours Category I Credit.

22-24, 11th Annual Advances in the Management of Infectious Diseases: Winter Update. **Location:** South Seas Plantation, Captiva Island, Florida. **Sponsor:** University of Michigan Medical School. **Contact:** Julie Jacobs, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 936-9800. **Approved for:** 13 hours Category I Credit.

March

3-6, A Symposium Featuring Fiberoptics - The Difficult Airway. **Location:** Red Lion's La Posada Resort, Scottsdale, Arizona. **Sponsor:** University of Michigan Medical School, Department of Anesthesiology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 15 hours Category I Credit.

10-15, Emergencies in Medicine. **Location:** The Yarrow A. Dunfey Resort and Conference Center, Park City, Utah. **Sponsor:** Detroit Receiving Hospital. **Contact:** Robert F. Wilson, MD, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit, MI 48201, (313) 745-3484. **Approved for:** 25 hours Category I Credit.

15-16, Recent Trends in Electrophysiologic Assessment Intraoperative Applications. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 13 hours Category I Credit.

19-23, Family Practice - 1991: Fifteenth Annual Spring Review Course. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School and Michigan Academy of Family Physicians. **Contact:** Julie Jacobs, Office of Continuing

Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 35 hours Category I Credit.

21-24, 11th Annual Advances in the Management of Infectious Diseases: Update. **Location:** South Seas Plantation, Captiva Island, Florida. **Sponsor:** University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 12 hours Category I Credit.

22, A Study in Hope: The Treatment and Management of Alzheimer's Disease. **Location:** Fetzer Development Center, Western Michigan University, Kalamazoo, Michigan. **Sponsors:** Michigan State University, Kalamazoo Center for Medical Studies, Alzheimer's Disease and Related Disorders, Chapter of SW Michigan, and Kalamazoo Neurology. **Contact:** Charles L. Zeller, Jr., MD, 1535 Gull Road, Suite 230, Kalamazoo, MI 49001, (616) 383-7363. **Approved for:** 6.5 hours Category I Credit.

April

4-5, Challenges and Changes: Obstetrics and Gynecology in the 1990's. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University Of Michigan Medical School, Department of Obstetrics and Gynecology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 15 hours Category I Credit.

10-12, Ultrasound in Obstetrics and Gynecology. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 21 hours Category I Credit.

29-May 5, Advances in Internal Medicine. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Internal Med-

icine. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 33.5 hours Category I Credit.

June

13-15, Microscopic Endolaryngeal Surgery: New and Advanced Techniques of Diagnostic Treatment. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology-Head and Neck Surgery. **Contact:** Julie Jacobs, Office of Continuing Medical Education, G-1100 Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor, MI 48109-0201, (313) 763-1400. **Approved for:** 20 hours Category I Credit.



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MEETINGS

MSMS Meetings

January

16, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

March

7, MSMS Young Physicians Section, Annual Meeting, Kellogg Center, East Lansing, MI. Contact: Debbie Zannoth, Chief, Membership Department (517) 337-1351.

13-14, Michigan Conference on Maternal & Perinatal Health, Ritz Carlton, Dearborn, MI. Contact: Sherry Fent, Chief, Physician Education (517) 337-1351.

16, MSMS Hospital Medical Staff Section Annual Assembly. Contact: E.B. "Tom" Plasman, Manager Physician/Hospital Relations, (517) 337-1351.

20, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

23, MSMS International Medical Graduates Annual Meeting, Ritz Carlton, Dearborn, MI. Contact: Judy Marr, Manager, Communications (517) 337-1351.

May

3-5, MSMS House of Delegates, Hyatt Regency, Dearborn, MI. Contact: William E. Madigan, MSMS Executive Director (517) 337-1351.

AMA MEETINGS

December

2-5, Interim Meeting of the House of Delegates, Marriott's Orlando World Center, Orlando FL. Contact: Stephanie Jaworskyj, Meeting Management (312) 464-5341.

February

15-17, National Leadership Conference, Fontainebleau Hilton, Phoenix, AZ. Contact: Stephanie Jaworskyj, Meeting Management (312) 464-5341.

Michigan Specialty Society Meetings

December

13, Midwest Conference on AIDS: Perspectives for the 1990s, Community Arts Auditorium, Wayne State University, Detroit, MI. Contact: (313) 577-5731 or (313) 577-0466.

April

21-23, Uniting to Support Infants and Families in Crisis, University of Michigan Campus, Ann Arbor, MI. Contact: Kathleen Baltman (313) 577-5244.

National Specialty Society Meetings

December

8-11, American Association for Respiratory Care, New Orleans, LA. Contact: (214) 243-2272

January

2-6, American Society of Law & Medicine; Obstetrics, Gynecology, Perinatal Medicine, Emergency Medicine, Bioethics and the Law, Jahaina, HI. Contact: Sharin Paaso, Associate Director (617) 262-4990.

February

18-20, Society of Thoracic Surgeons, San Francisco, CA. Contact: (312) 664-6610.

24-28, American Institute of Ultrasound in Medicine, Atlanta, GA. Contact: (301) 656-6117.

March

1-3, Neurology in Clinical Practice, Telemark Resort, Cable, WI. Contact: (507) 284-2509 or Toll Free (800) 323-2688.

1-6, American Academy of Allergy & Immunology, San Francisco, CA. Contact: (414) 272-6071.

3-7, American College of Cardiology, Atlanta, GA. Contact: (301) 897-5400.

7-12, American Academy of Orthopaedic Surgeons, Anaheim, CA. Contact: (708) 823-7186.

16-21, American Academy of Pediatrics - Spring Session, San Diego, CA. Contact: (708) 228-5005.

23-26, American Society on Aging, New Orleans, LA. Contact: (415) 543-2617.

April

11-13, American Society of Abdominal Surgeons, Tampa, FL. Contact: (301) 483-5471.

11-14, American College of Physicians, New Orleans, LA. Contact: (215) 351-2400.

21-25, American Association of Neurological Surgeons, New Orleans, LA. Contact: (708) 692-9500.

21-26, American Association of Immunologists, Atlanta, GA. Contact: (301) 530-7178.

21-27, American Academy of Neurology, Boston, MA. Contact: (612) 623-8115.

28-May 2, American Urological Association, Las Vegas, NV. Contact: (301) 727-1100.

29-May 3, American Pediatric Society, New Orleans, LA. Contact: (505) 764-9099.

May

3-6, Association of American Physicians, Seattle, WA. Contact: (609) 848-1000.

6-9, American College of Obstetricians and Gynecologists, New Orleans, LA. Contact: (202) 638-5577.

9-12, American Geriatrics Society, Chicago, IL. Contact: (212) 308-1414.

11-16, American Psychiatric Association, New Orleans, LA. Contact: (202) 682-6100.

18-24, Digestive Disease Week: American Gastroenterological Association, New Orleans, LA. Contact: (609) 848-1000.

19-23, American Association on Mental Retardation, Washington, DC. Contact: (202) 387-1968.

22-25, Society of Critical Care Medicine, Washington, DC. Contact: (714) 870-5243.

29-June 1, American College of Sports Medicine, Orlando, FL. Contact: (317) 637-9200.

CLASSIFIEDS

The rate for classified advertising in *Michigan Medicine* is 80 cents per word, with a minimum charge of \$40.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

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COMMUNITY OF BEAVERTON, MICHIGAN is recruiting for a full-time **Family Practitioner** to provide physician services to the residents of their area. Beaverton, located in Gladwin County, is in one of the fastest growing areas of the state and is known for its fishing, hunting, and other popular outdoor activities. The area is served by Mid-Michigan Regional Health System with affiliate hospitals in Gladwin, Clare and Midland. Offering a broad range of comprehensive medical services. For complete information regarding our competitive financial package, and the Beaverton area, please write to: Mike Mikolaizyk, President, Beaverton Business Association, 352 N. Ross, Beaverton, MI 48612.

CRNA for large regional Mid-Michigan hospital. Competitive salary and excellent fringe benefits, including fully-paid health and malpractice insurance. Most specialties with high percentage OB/GYN. Ideal **Great Lakes Location** for the sportsperson. Contact: Vickie Henige, Saginaw General Hospital, 1447 N. Harrison, Saginaw, MI 48602 (517) 771-4502.

DERMATOLOGIST, PSYCHIATRIST, ALLERGIST, INTERNAL MEDICINE, FAMILY PRACTICE: A progressive, 126-bed, two-hospital system is seeking the above specialties to establish practices in the **Iron Mountain** area of **Michigan's Upper Peninsula**. Must have BE/BC. Located 100 miles north of Green Bay,

Wisconsin. Dickinson County Hospital has a medical staff of 45 full-time physicians and a total service area population of over 45,000. Diagnostic capabilities include a CT scanner, CO2 laser, and a fully-staffed special diagnostic department. CONTACT: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, MI 49801, (906) 779-4500.

FAMILY PRACTICE...HOSPITAL-SPONSORED CLINIC OPPORTUNITY. Dynamic, growth-oriented hospital in beautiful **North Central Wisconsin** is seeking Family Physicians to respond to growing community demand. The administrative burdens of medical practice will be minimized in this hospital-managed clinic. The hospital has committed to an income and benefit package which is significantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact Kari Wangness, Associate, The Chancellor Group, Inc., France Place Suite 920, 3601 Minnesota Drive, Bloomington, Minnesota 55435, (612) 835-5123.

FAMILY PRACTICE – Physicians seeking a BE/BC family practice physician for the **Norway, Michigan**, service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr. Paul Hayes, Anderson Memorial Hospital, Main Street, Norway, MI 49870, (906) 563-9243 or office (906) 563-9255.

FAMILY PRACTICE – HOSPITAL-SPONSORED clinic opportunity. Dynamic, growth-oriented hospital in beautiful **North Central Wisconsin** is seeking two **family physicians** for a **new clinic** facility currently being constructed. The administrative burdens of medical practice will be minimized in this hospital-managed clinic. The hospital has committed to an income and benefit package which is significantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus, and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact Dan McCormick, President, Allen McCormick, France Place, Suite 920, 3601 Minnesota Drive, Bloomington, MN 55435, (612) 835-5123.

FAMILY PRACTICE – MINNESOTA – Physician needed for **employment** or **ownership** of broad-based practice in rural community 45 minutes south of metro area. Existing shared call, tremendous earning history of retired physician, fully equipped and staffed office. Near outstanding hospital with all specialties represented. Guaranteed compensation, full

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GAYLORD / WEST BRANCH AREA: Full-time **emergency department** positions available at moderate volume facility located in beautiful Northern Michigan. Hourly compensation and malpractice insurance provided. Benefit package available to full-time physicians. Contact: Betty Looze, Emergency Consultants, Inc., 2240 South Airport Road, Room 23, Traverse City, MI 49684, (800) 253-1795 or in Michigan (800) 632-3496.

GENERAL INTERNIST: Marshfield Clinic, a growing, nationally-recognized 350-physician comprehensive multi-specialty group, seeks BC/BE general internists to join its 30-member section in **Marshfield** and regional centers in **Central and Northern Wisconsin**. Skilled colleagues, democratic governance, modern facilities, state-of-the-art equipment, postgraduate training programs, clinical research, diverse practice opportunities, competitive salaries/benefits, an expanding regional health care system, an extremely low physician turnover rate (3.4%), and an unwavering commitment to quality patient care all contribute to a stimulating, satisfying, secure professional environment. The unpolluted tranquil rural location, outdoor recreation, low crime rate, and excellent school system present an ideal family environment. At present, we offer the qualified general internist a variety of locations and practice opportunities. Including: 1) Traditional general internal medicine practice; 2) Scheduled practice in immediate care or emergency care; 3) Focused practice in perioperative medical care, chemical dependency, geriatrics or psychiatric unit medicine. Send CV to: David L. Draves, Director of Physician Recruitment, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449. Or call (800) 826-2345, extension 5376.

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HEMATOLOGY-ONCOLOGY: Be a part of a thriving **Group Practice** located in **Southern Indiana**. Affiliated with a 590-bed regional referral center. Competitive salary plus malpractice insurance and other physician perks. Send CV to: Don Hoit, 11222 Tesson Ferry Rd., Suite 203, St. Louis, Missouri 63123 or call (800) 336-3963.

INTERNIST & FAMILY PRACTITIONER (BE/BC REQUIRED). Due to our rapid growth and the expansion of our member population, SelectCare's MedExtend/HMO currently has full and part-time practice opportunities available at our **Sterling Heights, Troy and Warren** health centers. SelectCare's MedExtend/HMO is a progressive 80,000-member managed care organization, committed to high-quality comprehensive medical care and wellness promotion. Physicians who share this commitment and seek affiliation with an innovative healthcare organization and several of the finest hospitals in Southeastern Michigan are invited to forward a resume or CV to SelectCare's physician recruitment office at 363 West Big Beaver, Troy, MI 48084, or contact us at

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MICHIGAN CITY, INDIANA: Seeking full-time and part-time **emergency physicians** for 99-bed, low-volume hospital emergency department within hours drive of Chicago. Excellent compensation, paid malpractice and full benefit package to full-time staff. Opportunity for advancement. Contact Emergency Consultants, Inc., 2240 South Airport Road, Room 23, Traverse City, MI 49684, (800) 253-1795 or in Michigan (800) 632-3496.

MICHIGAN, SOUTHWEST: PHYSICIAN FOR EMERGENCY SERVICES. Community Emergency Departments, urgent care center, physician staffed helicopter. Board eligible or certified in emergency medicine/internal medicine/family practice/general surgery or appropriate

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NEW YORK, WESTERN – Seeking primary care trained physicians for full-time **Emergency Department** positions. Moderate volume. Attractive hourly compensation, plus malpractice insurance. Benefit package available to full-time physicians. Director position available. Contact: Emergency Consultants, Inc., 2240 S. Airport Rd., Room 23, Traverse City, MI 49684, (800) 632-3496.

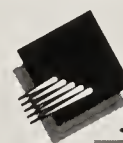
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OSHKOSH, WISCONSIN: Four BC Internists seek fifth associate to join flourishing

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PITTSBURGH AREA: New fee for service ED group at The Medical Center in **Beaver, Pennsylvania** is seeking an **Associate Director**, full-time and part-time **emergency physicians** for this 475-bed level II center. Double and triple coverage during peak periods provides reasonable patient load. New fast track area, excellent medical staff back-up, CEN certified ED nurses, and full administrative support. Outstanding compensation and paid malpractice insurance. Benefit package available to full-time staff. Board eligibility or certification in emergency medicine or primary care specialty, and ACLS required. Contact: Karen Remai, Emergency Consultants, Inc., 2240 S. Airport Rd., Room 23, Traverse City, MI 49684, (800) 253-1795.

PRIVATE PRACTICE OPPORTUNITIES exist in **Southern Indiana** affiliated with a 590-bed hospital. Specialties include **Internal Medicine** and **Family Practice.** Competitive compensation plan and attractive partnership arrangement available. Send CV to Don Hoit, 11222 Tesson Ferry Rd., Suite 203, St. Louis, MO 63123 or call (800) 336-3963.

RADIOLOGIST: A three-physician radiology group is seeking a fourth radiologist with experience and interest in interventional radiology. Dickinson County Hospitals is a progressive, 126-bed, two-hospital system, located in **Iron Mountain, Michigan's Upper Peninsula.** We have a service area population of over 45,000. Contact and/or send resume: Doctors Specht/Shampo/Manzano, Radiology Department, Dickinson County Hospital, 400 Woodward Avenue, Iron Mountain, MI 49801, (906) 779-4565.

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Continued from previous page

cialize in partnership development and practice analysis. Protect your interests! Call Richard Corey, CMDC, Medical-Dental Management Consultants Corp., 31158 Perrys Crossing, Farmington Hills, MI 48331. Call day (313) 661-0888 or night (313) 661-0404.

BEAUTIFUL SOUTHWEST MONTANA ... PRACTICE FOR SALE. Boating, fishing, camping, hunting, and skiing at your doorstep. Family Practice with terminations of pregnancy. Price: \$50,000...negotiable. Reply with CV to: *Michigan Medicine*, P.O. Box 950, Attn: SJD, East Lansing, MI 48826.

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PRACTICE FOR SALE: Excellent **family practice** and walk-in care facility. Desirable modern up-to-date equipped office in the **Southfield - Lathrup Area.** Great visibility, signboard and parking a plus. Must sell due to health reasons. Lots of growth potential. Call: Lainie (313) 683-3733.

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BOARD CERTIFIED RADIOLOGIST: APPROVED B READER...ALSO available for part-time position in Diagnostic Radiology. My experience and practice includes Ultrasound, Nuclear Medicine, CT and Special Procedures. Respond to: A.R. Sadik, MD, 2820 W. Maple Rd., Suite 130, Troy, MI 48064, phone (313) 643-7310.

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PRESIDENT'S PAGE

We need to do more things that benefit MSMS members only

By Susan H. Adelman, MD



MSMS members often urge us to develop a public relations program to tell the public how much physicians care about them, how much the medical society is doing to promote the standards of the profession, and what MSMS stands for. Presumably these suggestions do not come from physicians who have a part interest in a public relations firm, so we must assume that this recommendation is made in all good faith, perhaps without knowledge of how much this type of campaign costs.

The public image of medicine is made up of an accumulation of impressions made by those in the profession. If we were all humane, sympathetic practitioners, of modest means, dedicated only to the welfare of our patients, with easily accessible, underpriced services of a uniformly excellent quality, we would have no public relations problem to solve. To the extent that we depart from that ideal, our problems begin.

If we had a world class public relations campaign, but still we were all arrogant, overpriced, selfish, inaccessible, and practiced poor quality medicine, nothing could help us. Of course it is possible that all of us could be saints, but that a negative media campaign against medicine could put us in need of our own media campaign to neutralize the damage. In all fairness, to some extent, this is now the case.

What complaints about doctors do we most commonly hear from our own family members? I hear: 1) The bill was too high;

2) The waiting time was too long, either to make the appointment or in the office waiting room; and 3) The doctor seemed to be in such a hurry that he did not listen to half of what we tried to say.

Fortunately I seldom hear that the doctor's services were of poor quality, but as president of MSMS I have heard disturbing examples of the latter concern.

If these are our problems, it would seem that our best, most effective public relations strategy would be to address them directly, one by one. These complaints are also the excuses that labor and big business use, so they can gleefully claim that poor quality is a reason why our whole medical system should be reformed, or replaced with a Canadian-type system. These are the same excuses that lawyers use to justify the tort system, and to oppose introduction of a no-fault system, which they say would not adequately frighten physicians into cleaning up our collective and individual act. These complaints are also the sources of public hostility toward the profession that government uses to build up support for budgetary maneuvers to cut our payments. It is high time we do something.

We have a different problem in organized medicine. Specialty societies, hospitals, hospital-associated physician associations, university faculties, HMOs, and other managed care organizations all compete with the AMA and state medical societies for membership, prestige, services and physician loyalty. If only we could offer a service, or a guarantee of excellence, that the others do not, we could better compete with these other organizations, and we might even be able to address the basic complaints about physicians that we talked about in the beginning of this article.

MSMS and organized medicine have another problem. Almost everything we do for our members also benefits nonmembers, but nonmembers can obtain these same benefits without paying dues. We need to do more things for members only.

Let us fantasize together. What if we

undertook the following membership campaign:

1) Each MSMS member would be offered the opportunity to sign a document comprised of: the recently-passed AMA Patient Bill of Rights (which appears on page 36 of this issue for your careful review), a statement saying that the physician's fees will be reasonable, and a statement saying that the physician's office waiting times (and waiting periods for appointments) will be appropriately short.

2) Members would be encouraged to post the signed document prominently in their offices.

3) A publicity campaign would encourage patients to check whether their doctor is an MSMS member, to look for the posted, signed document, and to verify that their doctor complies with it.

4) If the doctor does not comply, the campaign would indicate that the patient should send a letter to MSMS, so MSMS could compile a "Doctor Report" for each physician member who participates in the program.

5) The report and copies of any letters received about his or her practice would be sent to the doctor each year, and the doctor could post this report in the office, if desired.

6) MSMS could then go to MPMLC and PICOM to negotiate 10-15 percent discounts in professional liability premiums for all physicians whose "Doctor Reports" showed fewer than a designated number of complaints per year, after a reasonable attempt has been made to screen out crank letters.

Crazy? Maybe. The point is that we need to identify membership in MSMS with quality, with concern for patients and their priorities, and with attempts to keep charges down to reasonable limits. We also need to translate this into a tangible benefit for members, such as lowered insurance premiums.

I am not saying whether or not I can sell this idea to very many of you, but surely all of you can see its purpose. Anybody want to try it out?

Doctor Adelman is MSMS president.

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